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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03562

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9154 Browns Lane</b>		d. STREET ADDRESS <b>9154 Browns Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Olga Hays Allen</b>		4. DATE OF DEATH Month <b>March</b> Day <b>14th.</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Typist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>
13. FATHER'S NAME <b>Otis Lenn Hays</b>		14. MOTHER'S MAIDEN NAME <b>Minnie May Cason</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>247-34-9335</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Gun shot wound of the head</b> (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot self in the head</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in the head</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:15 p.m. 3/14 19 62</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20e. (City or town) <b>Lanham</b>		20f. (County) <b>P.G.</b>	
20g. (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/15/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 19, 62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Silver Brook Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Anderson, S. Car</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers &amp; Riverdale Md.</b>		24a. REC'D BY REGISTRAR <b>Mar 19 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03570

Items 11 &amp; 12 Film G310 4/2/62 mh

## CERTIFICATE OF DEATH

03563

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>25 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Mt. Rainier</b> d. STREET ADDRESS <b>3271 Queenstown Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Theresa K. Allen</b>		4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-8-17</b>
9. AGE (In years last birthday) <b>45</b>		10. IF UNDER 1 YEAR Months <b>45</b> Days <b>17</b>	
11. IF UNDER 24 HRS. Hours <b>17</b> Min. <b>45</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. Beckert</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Casassa</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Arthur M. Allen, 3271 Queenstown Drive</b>		Address <b>Mt. Rainier, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> 199X DUE TO <b>Cardiomyopathy</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardiomyopathy</b> (c) <b>Cardiomyopathy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>199X</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Mar 3</b> 19 <b>62</b> to <b>Mar 28</b> 19 <b>62</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>3/28</b> 19 <b>62</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel J. N. Sugar</b> M.D.		22b. DATE SIGNED <b>Mar 28 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>		22d. ADDRESS <b>4637 EASTERN AVE WASH DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/2/62</b>		23b. DATE THEREOF <b>4/2/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>St. Hines Co</b>		25a. REC'D BY REGISTRAR <b>2901 145th NW</b>	
25b. REGISTRAR'S SIGNATURE <b>DATE MAR 30 '62</b>		25c. REGISTRAR'S SIGNATURE <b>DATE MAR 30 '62</b>	

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1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03571

03564

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TB <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mitchelville</b> d. STREET ADDRESS <b>Rt. 2 Box 12</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Solomon G. Alston</b>			4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 62</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-12</b>	9. AGE (In years last birthday) <b>49 yrs.</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b></b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b></b>		
13. FATHER'S NAME <b>Roland Alston</b>			14. MOTHER'S MARDEN NAME <b>Mary Jones</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) <b></b>			16. SOCIAL SECURITY NO. <b></b>		
17. INFORMANT <b>Amy Henry - Mitchelville, Maryland</b>			Address <b></b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, right internal capsule</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>		20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3-3</b> , 19 <b>62</b> , to <b>3-11</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3-11</b> , 19 <b>62</b> , and that death occurred at <b>7:30</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>David S. Clayman</b> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/12/62</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. David S. Clayman</b>			22d. ADDRESS <b>6311 Baltimore Ave., Riverdale, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/15/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jones Cemetery</b>	
23d. LOCATION (City, town or county) <b>Mitchelville, Md.</b>		23e. REC'D BY REGISTRAR <b>George L. Kalson</b>		23f. REGISTRAR'S SIGNATURE <b>George L. Kalson</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George L. Kalson</b>			24b. ADDRESS <b></b>		

1950

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George Washington University  
School of Medicine  
Department of Pathology  
Washington, D.C.

Dr. J. H. Brown  
Dr. J. H. Brown  
Dr. J. H. Brown

Dr. J. H. Brown  
Dr. J. H. Brown  
Dr. J. H. Brown

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Dr. J. H. Brown

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03572

03565

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>6425 31st Place N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>OMER</u> Middle <u>LEE</u> Last <u>ARBUCKLE</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>28</u> Year <u>1962</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4/20/83</u>		<b>9. AGE</b> (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>28</u> IF UNDER 24 HRS.: Hours <u>7</u> Min. <u>28</u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Civil Engineer U.S. Government</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Government</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Indiana</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Alexander H. Arbuckle</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>same as #2</u> <u>Doris V. Hobbs</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>Benign Prostatic Hypertrophy</u> (c) <u>ANURIA, GENERALIZED ARTERIO-SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (If any) <u>✓</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 1/2 months</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>11-2-58</u> <b>to</b> <u>3-28-62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3-28-62</u> <b>and that death occurred at</b> <u>11:00 AM</u> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>David S. Gordon</u>						<b>22b. DATE SIGNED</b> <u>3-28-62</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>David S. Gordon</u>		<b>22d. ADDRESS</b> <u>5731 23rd PARKWAY SE Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>				<b>23b. DATE THEREOF</b> <u>3/31/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Cemetery</u>				<b>23d. LOCATION (City, town or county)</b> (State) <u>Prince Georges County, Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>2901 14th St. N.W. Washington 9, D.C.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>DATE</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>3-30-62</u>					

MEDICAL CERTIFICATION

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR. PAGE 4 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

03332

STATEMENT OF DEATH

00202

1

STATEMENT OF DEATH

NAME: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

REPORTED BY: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

LOCATION: [illegible]

REMARKS: [illegible]

03573

## CERTIFICATE OF DEATH

Item 2 Film G300 3/23/62 iwr

03566

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie Box 281</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>			
c. LENGTH OF STAY IN 1b <u>22 yrs.</u>				d. STREET ADDRESS <u>Box 281</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>VIOLET</u> Last <u>ARNOLD</u>				4. DATE OF DEATH Month <u>MAR.</u> Day <u>10</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1912</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>49</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Prince Geo. Co. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD BROOKS</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA DOWNS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Box 275, Md.</u> <u>Mrs. Dorothy Duckett Bowie, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 592X DUE TO (b) <u>Severe Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Renal Disease - Chronic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-8 hrs.</u> <u>Many years</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month. Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>Mar. 8, 1962 to Mar. 10, 1962</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 8, 1962</u> to <u>Mar. 10, 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar. 10, 1962</u> , and that death occurred at <u>4A</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry A. Wise Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HENRY A. WISE, JR.</u>				22d. ADDRESS <u>149 9th St. Bowie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bowie, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John T. ...</u>				ADDRESS <u>3015-125th St.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 15 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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James Thompson  
Baltimore, Md. 22 yrs



# 1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

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5M 1/62

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03574 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03567

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Roger Heights</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>5014 55th Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>CATHERINE BERNIECE BAKER</b>				4. DATE OF DEATH <b>March 24 19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1912</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Comptometer Operator Beauty Supply</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UPPERMARCH BORO</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexander (n) Moore</b>				14. MOTHER'S MAIDEN NAME <b>Hattie M. Ryon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-245837</b>		17. INFORMANT <b>Harry C. Baker</b>		Address <b>5014 55th Ave., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion &amp; Edema</b> DUE TO (b) <b>Glioma of left frontal lobe of brain.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/24/62</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-28-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WASH NATL CEM</b>		22d. LOCATION (City, town, or country) (State) <b>SUITLAND MD</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers</b>				ADDRESS <b>517-11<sup>th</sup> ST SE</b>		24a. REC'D BY REGISTRAR <b>MAR 29 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

MEDICAL CERTIFICATION

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The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03575

## CERTIFICATE OF DEATH

Item 7 Film G309 3/27/62 iwk

03568

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>So. America</b> b. COUNTY <b>So. America</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maracaibo, Venezuela</b>	
3. NAME OF DECEASED (Type or print) First <b>ALMER</b> Middle <b>W</b> Last <b>BEALE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Married <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Nov. 1913</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months <b>48</b> Days <b>48</b>	11. IF UNDER 24 HRS. Hours <b>48</b> Min. <b>48</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Marine - Oil Co. Maine</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Almer W. Beale</b>		14. MOTHER'S MAIDEN NAME <b>Verna Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>	
17. INFORMANT <b>Emily Beale, 4900 Cherokee St.</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>578X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Pentamite</b> <b>must put in the large bowl.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3/19/62</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 6, 1962</b> to <b>March 19, 1962</b> that (I) (we) last saw the deceased alive on <b>March 19, 1962</b> , and that death occurred at <b>3:00AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W.C. Etienne</b>		22b. DATE <b>3/19/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.C. Etienne</b>		22d. ADDRESS <b>College Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-22-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cemetery, Arlington, Va.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Sawlis Sons</b>		25. REC'D BY REGISTRAR <b>1756 Pa. Ave. N.W. Wash. D.C.</b>	
25. REC'D BY REGISTRAR <b>MAR 22 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03576 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03569

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Hillside</b>				
c. LENGTH OF STAY IN <b>D.O.A.</b>					d. STREET ADDRESS <b>5400 M Street</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Margaret</b> Last <b>Bell</b>					4. DATE OF DEATH <b>March 7, 1962</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 22, 1919</b>		9. AGE (In years last birthday) <b>42 yrs.</b>	
						IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>42</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>				
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Lamuel Foard</b>					14. MOTHER'S MAIDEN NAME <b>Catherine Rohe</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>577-14-0089</b>				
17. INFORMANT <b>Robert Harry Bell</b>					Address <b>same as #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>LOBAR PNEUMONIA</b>									
470X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>SEVERE FATTY LIVER</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>James I. Boyd</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>3/7/62</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					22b. DATE THEREOF <b>3-12-1962</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Burlington National</b>					22d. LOCATION (City, town, or county) <b>Arlington Virginia</b>				
23. FUNERAL DIRECTOR <b>W.W. Chambers Co., Riverdale, Md</b>					24a. REC'D BY REGISTRAR <b>MAR 9 '62</b>				
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>				

MEDICAL CERTIFICATION

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03577

03570

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Carrollton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>6402 - 85th Place</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Garfield B. Berry</b>				4. DATE OF DEATH Month Day Year <b>March 8 19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-27-82</b>	
9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lithographer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Emory Berry</b>				14. MOTHER'S MAIDEN NAME <b>(unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None None</b>				17. INFORMANT Address <b>Hattye P. Berry 6402 85th Pl. Carrollton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>260X Cerebral artery thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary heart failure</b> DUE TO (c) <b>Diabetic mellitus</b> <b>Generalized atherosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>5 yrs</b> <b>5 yrs</b> <b>5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 Feb 1962</b> to <b>8 Mar 1962</b> that (I) (we) last saw the deceased alive on <b>7 Mar 1962</b> and that death occurred at <b>4:55 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John Kehoe</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John Kehoe</b>				22d. ADDRESS <b>1835 Eye Street, N.W., Washington, D. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-12-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
24. FUNERAL DIRECTOR'S NAME (Type) <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>							

03320

CONFIDENTIAL OR SECRET

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James Earl Ray

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03578

Item 3 File 330 4/22/62 md

CERTIFICATE OF DEATH

03571

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Kent</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. LENGTH OF STAY IN 1b <i>50 yr +</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4807 - Tuckers St Gershon</i>		d. STREET ADDRESS <i>70</i>	
3. NAME OF DECEASED (Type or print) <i>Gershon</i> First <i>P</i> Middle <i>Bick</i> Last <i>Ferd</i>		4. DATE OF DEATH <i>Mar 20 19 62</i> Month <i>Mar</i> Day <i>20</i> Year <i>19 62</i>	
5. SEX <i>M</i>	6. COLOR OF RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 15, 1872</i>
9. AGE (In years lost birthday) <i>89</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Aathan Bickford</i>		14. MOTHER'S MAIDEN NAME <i>Arabelle Cohn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Aurelia E Bickford</i>		Address <i>College Park, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ac Congestive Heart Failure</i> <i>434.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchopneumonia, left lower</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>3/4 11:55</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>College Park, MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>3/4</i> to <i>3/20 62</i> , that (I) (we) last saw the deceased alive on <i>3/18 62</i> , and that death occurred at <i>11:55</i> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Etienne</i> M.D.		22b. DATE SIGNED <i>3/20/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.C. ETIENNE</i>		22d. ADDRESS <i>College Park, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar 23, 1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington D C</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 27 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

14

CHIEF OF POLICE

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03579  
03572

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY									
Prince Georges		Cheverly		Maryland		Prince Georges									
		10 hr		30 Fairmont Heights											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
Prince Georges General Hospital				5709 J Street											
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH											
First Middle Last				Date Month Day Year											
Baby Girl Blackwell				March 18 1962											
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
Female		Black				17 March 1962						10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
None								Maryland				U.S.A.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
Henry R obert Blackwell						Shirley Romaine Holden									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address									
						Mother Same									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)															
762.5 DUE TO Prematurity (2 lbs 12 oz)															
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Atletasis															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
19															
21. I certify that (I) (this hospital) attended the deceased from 3-17 1962 to 3-18 1962, that (I) (we) last saw the deceased alive on 3-18 1962, and that death occurred at 12:05 AM from the causes and on the date stated above.															
22a. SIGNATURE												22b. DATE SIGNED			
Thomas A. Christensen M.D.												3/19/62			
22c. PHYSICIAN'S NAME (Type)												22d. ADDRESS			
Dr. Thomas A. Christensen												6905 Baltimore Ave., College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)					
Cremation				3-31-62		Prince Geo. Gen. Hospital				Cheverly, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS												25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Harry W. Penn, Jr., Administrator												APR 3 '62		Arthur S. Penn	

VA-15 (4)  
15M 7/61

2-045932

5724



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03573

13  
FOR STATE  
HEALTH DEPT.

03580

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. STREET ADDRESS 46 Brentwood 1			
3. NAME OF DECEASED (Type or print) First Middle Last Ida Eva Elizabeth Bowen				4. DATE OF DEATH March 7, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	
11. BIRTHPLACE (State or foreign country) Illinois Quincy		12. CITIZEN OF WHAT COUNTRY? U. S.A.		13. FATHER'S NAME Benjamin Bowen		14. MOTHER'S MAIDEN NAME Louisa Weisenburger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Nell Louise Bowen, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cardiovascular renal disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the liver							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		JAMES I. BOYD, M.D.				DATE SIGNED 3/7/62	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/9/62		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Nalley's Funeral Home		Mt Rainier, Md.		DATE MAR 12 '62		Arthur S. Francis	

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

03581

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03575

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Washington</b> b. COUNTY <b>D.C.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Temple Hills</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6431 Gull Road</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, DC</b>			
3. NAME OF DECEASED (Type or print) <b>KALMAN (N) BRETLER</b>				d. STREET ADDRESS <b>1116 K St., N.E.</b>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>July 10, 1883</b>			
9. AGE (In years last birthday) <b>78</b> yrs.				10. IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b>			
11. BIRTHPLACE (State or foreign country) <b>Austria</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Leah B. Biller</b>				Address <b>2410 N. Randolph St., Va. Arlington, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Coronary artery disease</b>							
(c) <b>Cardiovascular renal disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James J. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>3/24/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-26-62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>National Capital Hebrew Cem.</b>				22d. LOCATION (City, town, or country) (State) <b>Washington, DC</b>			
23. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>				24a. REC'D BY REGISTRAR <b>3501 14th St. NW</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

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Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03582 CERTIFICATE OF DEATH 03576

1. PLACE OF DEATH e. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>7 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>305 - 67th. Place</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>M.</b> Last <b>Brickerd</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-13-02</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b>		IF UNDER 24 HRS. Hours <b>10</b> Min. <b>10</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>7-13-1918-3-22-1919</b>		11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>DENNIS BRICKERD</b>				14. MOTHER'S MAIDEN NAME <b>MARY HURLEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give year or dates of service) <b>7-13-1918-3-22-1919</b>				16. SOCIAL SECURITY NO. <b>577-01-6907A</b>			
17. INFORMANT <b>Mary Rooney</b> Address <b>6000 Millaw Dr Seat Pleasant Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4 Congestive Heart Failure</b> DUE TO <b>20.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>Anteriodicentric Heart Disease</b> DUE TO <b>4</b> (c) <b>20.0</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchogenic carcinoma</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-12-62</b> , 19 <b>62</b> to <b>3-18-62</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3-18-62</b> , and that death occurred at <b>10:10 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George W. Ware</b> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. George W. Ware</b>				22d. ADDRESS <b>1835 Eye St., N. W., Washington 6, D. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>3/21/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cmt</b>		23d. LOCATION (City, town or county) (State) <b>Arlington VA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Lee - Wash. D.C.</b> ADDRESS				25a. REC'D BY REGISTRAR <b>MAR 22 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Dennis" and "Bureau" are faintly visible.]*



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03583

03577

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AIR FORCE BASE, MD.</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>OKLAHOMA</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AIR FORCE BASE McMann</u> d. STREET ADDRESS <u>/CAMP SPRINGS/ Box 328</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WARREN</u> Middle <u>RAY</u> Last <u>BROCKETT</u>				<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>9</u> Year <u>1962</u>													
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JULY 17, 1940</u>		<b>9. AGE</b> (In years last birthday) <u>21</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>AIRMAN</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>US AIR FORCE</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MAUD, OKLAHOMA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>UNITED STATES</u>									
<b>13. FATHER'S NAME</b> <u>JOE B BROCKETT</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>LAVURN STRICKLAND</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> (If yes, give year or dates of service) <u>1959 - 1962</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>FATHER</u>		Address <u>BOX 328, MCMANN, OKLAHOMA</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBELLAR TONSILLAR HERNIATION</u> DUE TO <u>902.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL EDEMA</u> DUE TO (c) <u>CONCUSSION</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>3 DAYS</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE DISLOCATION C5 - C6, SPINAL CORD COMPRESSION; SUBARACHNOID HEMORRHAGE</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>FELL OFF OF POWER POLE</u>													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>7:30</u> p.m. <u>MAR 6</u> 19 <u>62</u>				<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Nat while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>ANDREWS AFB</u>		<b>20f. (City or town)</b> <u>PRINCE GEORGES MD</u> (County) (State)									
<b>21. I certify that</b> <u>XX</u> (this hospital) attended the deceased from <u>6 MAR</u> 19 <u>62</u> , to <u>9 MAR</u> 19 <u>62</u> , that <u>XX</u> (we) last saw the deceased alive on <u>9 MAR</u> 19 <u>62</u> , and that death occurred at <u>10:15A</u> from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <u>Gerald Schuster</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9 MARCH 1962</u>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>GERALD SCHUSTER, Capt USAF MC</u>				<b>22d. ADDRESS</b> <u>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD.</u>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>SHIP RA</u>		<b>23b. DATE THEREOF</b> <u>3-11-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Seminole Oklahoma</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers</u>				ADDRESS <u>517-11th St S.E.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 14 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Harris</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03584 CERTIFICATE OF DEATH 03578

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TB <b>3 Hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45 Brentwood</b> d. STREET ADDRESS <b>4509 41st Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Diane</b> First Middle Last <b>Brooks</b>			4. DATE OF DEATH Month Day Year <b>March 6 19 62</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-6-61</b>	9. AGE (In years last birthday) yrs. <b>7</b>	IF UNDER 1 YEAR Months Days <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's County, Md.</b>	
13. FATHER'S NAME <b>Roland James Bailey</b>			12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Mother</b>			Address <b>Same as above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) <b>491X</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>19</b>	
20f. (City or town) <b>3-6-62</b>		20g. (County) <b>3-6-62</b>		20h. (State) <b>3-6-62</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3-6-62</b> to <b>3-6-62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3-6</b> 19 <b>62</b> , and that death occurred at <b>3:24 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Thomas A. Christensen</b> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen</b>			22d. ADDRESS <b>6905 Baltimore Avenue, College Park, Md.</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-15-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>	
23d. LOCATION (City, town or county) <b>Suitland, Maryland</b>		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE <b>John Rhines</b>			ADDRESS <b>3015 12th St. N.E.</b>		DATE <b>MAR 15 '62</b>
25a. REC'D BY REGISTRAR <b>Walter S. Thayer</b>			25b. REGISTRAR'S SIGNATURE		

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Place of Birth: Maryland

Gender: Male

Place of Birth: 4800 4th Avenue

Place of Birth: 4800 4th Avenue

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03585

CERTIFICATE OF DEATH

03579

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Maryland</i>				b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Suitland</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>District Heights</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suitland Nursing Home, Inc.</i>				d. STREET ADDRESS <i>7310 Insey St.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary E. Brooks</i>				4. DATE OF DEATH Month <i>March</i> Day <i>30</i> Year <i>1962</i>							
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/1/83</i>		9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>C.S. Commission</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>			
13. FATHER'S NAME <i>Thomas Oaden</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>W.M. Brooks, 7310 Insey St., Dist. Hts</i>				17. INFORMANT <i>W.M. Brooks, 7310 Insey St., Dist. Hts</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Embolism</i> 443 X DUE TO (b) <i>Hypertensive arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <i>Chronic Cerebro-Vascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>45 MINS. 6-8 YRS. 3-4 M/O</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>1953</i> to <i>MARCH 30, 1962</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>3/30/62</i> 19 <i>53</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Sidney W. Lowry</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>SIDNEY W. LOWRY</i>				22d. ADDRESS <i>7200 MARLBORO PIKE S.E</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>4-2-62</i>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>			
								23d. LOCATION (City, town or county) (State) <i>Suitland, Md</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. LEE</i>				ADDRESS <i>300 4 ST NE</i>				25a. REC'D BY REGISTRAR DATE <i>APR 6 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03580

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4, should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Robert Brown</b>			4. DATE OF DEATH <b>March 3 1962</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Colored</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <b>Dec. 4, 1918</b>		
9. AGE (In years last birthday) <b>43</b> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>		
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Manes Brown</b>			14. MOTHER'S MAIDEN NAME <b>Mady Harrison</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>W.W. 11</b>		
17. INFORMANT <b>Betty Brown</b>			Address <b>Same as #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>3/9/62</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Ceme.</b>			22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR <b>John B. Stewart</b>			24a. REC'D BY REGISTRAR <b>12 '62</b>		
ADDRESS <b>40 H Street, N.E. D.C.</b>			24b. REGISTRAR'S SIGNATURE <b>Charles L. Kimura</b>		

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03587

03581

1. PLACE OF DEATH e. COUNTY <b>Prince Georges'</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Landover</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
c. LENGTH OF STAY IN 1b <b>10 Mos.</b>		d. STREET ADDRESS <b>--</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Largo Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Alfred</b> Last <b>Bryan</b>		4. DATE OF DEATH Month <b>MAR</b> Day <b>11</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1881</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Margaret (nee Bryan)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>James Alonzo Bryan--Landover, Md.</b>	
17. INFORMANT <b>James Alonzo Bryan--Landover, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-20-1 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Coronary Artery Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>15 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1952</b> , to <b>MAR 11, 1962</b> , that (I) (we) last saw the deceased alive on <b>1 MAR 1962</b> , and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert B. Sasscer</b>		22b. DATE SIGNED <b>3/11/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M.D.</b>		22d. ADDRESS <b>Upper Marlboro, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/15/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Rosaryville Md.</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home--Upper Marlboro</b>		25a. REC'D BY REGISTRAR <b>MAR 21 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1. The first group of people who are not allowed to enter the country are those who are not citizens of the United States.

1994

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## SUMMARY

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Libbie Bros., Inc., 1001 Broadway

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3588  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Kentucky b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Louisville	
c. LENGTH OF STAY IN 1b Transient		d. STREET ADDRESS 3328 Illinois Ave.,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 197		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence J. Bryant		4. DATE OF DEATH March 7th, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1914
9. AGE (In years last birthday) 47 <sup>rs</sup>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom		10b. KIND OF BUSINESS OR INDUSTRY Race Track	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl Bryant		14. MOTHER'S MAIDEN NAME Dora Willoughby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 11		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT GODFREY F. RUSSMAN		Address 1041 Goss Ave Louisville, Ky.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull & left knee 823X DUE TO crushed chest & fracture of left clavicle Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of automobile that ran off road	
20c. TIME OF INJURY Month, Day, Year Hour <del>XX</del> p.m. Mar 7 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 197		20f. (City or town) Laurel (County) P.G. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-1962	
22c. NAME OF CEMETERY OR CREMATORY Cave Hill Cemetery		22d. LOCATION (City, town, or country) Louisville, Kentucky	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		24a. REC'D BY REGISTRAR MAR 14 '62	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS  
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03589

03583

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Takoma Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1003 Hopewell Avenue</b>		d. STREET ADDRESS <b>1003 Hopewell Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Wyman</b> Last <b>Campbell</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 62</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/ 1948</b>
9. AGE (In years lost birthday) <b>13</b> yrs.		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min. <b>13</b>	11. IF UNDER 24 HRS. Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min. <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clyde B. Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Howe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Clyde B. Campbell</b>		Address <b>1003 Hopewell Avenue Takoma Park, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Retrospectival Malignancy</b> <b>158X</b> DUE TO <b>Diagnosis of other cause</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 Mo</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 14, 1962</b> to <b>March 15, 1962</b> that (I) <b>(was)</b> last saw the deceased alive on <b>March 14, 1962</b> and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Harold Hecy</b>		22b. DATE SIGNED <b>3/15/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harold Hecy</b>		22d. ADDRESS <b>1835 Eye St N.W. DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/19/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co.-2901 14th St., N.W.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 19 '62</b>	
ADDRESS <b>Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	



David Rogers MD

Boy has been under care of Robert  
Bosworth, MD whilst a patient at Sibley Hospital.

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

03590  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 03584

1. PLACE OF DEATH a. COUNTY <u>Prince Georges'</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>39 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5300 GALLATIN ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EVA FLORA CLARKE</u>				4. DATE OF DEATH <u>MARCH 20 1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 18 1899</u>	
9. AGE (In years lost birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-32-0699</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ADENO CARCINOMA PANCREAS</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>1 1/2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1954</u> to <u>3/20 1962</u> that I last saw the deceased alive on <u>3/20 1962</u> , and that death occurred at <u>12:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Comeru</u> M.D. <u>3503 PENNY ST</u>				DATE SIGNED <u>3/20/62</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMERU</u>				MT PLAIN MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-22-62</u>		<u>WASHINGTON NATIONAL</u>		<u>SCITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Eburner &amp; Co. Riverdale</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 23 '62</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							

10220

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03531 CERTIFICATE OF DEATH 03585

1. PLACE OF DEATH e. COUNTY <b>Prince George's</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> g. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>35 Huntsville</b> d. STREET ADDRESS <b>1101 70th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Coates</b>		4. DATE OF DEATH <b>3-18-1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Augustine Queen</b>		Address <b>7273 Kolb Street, N.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor &amp; dehydration</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. <b>491X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-17</b> , 1962 to <b>3-18</b> , 1962, that (I) (we) last saw the deceased alive on <b>3-18</b> , 1962, and that death <b>7:20</b> at <b>P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>David S. Clayman</b>		22b. DATE SIGNED <b>3/19/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. David S. Clayman</b>		22d. ADDRESS <b>6311 Ba Ho Ave Riverdale, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/16/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Blair J. Stewart</b>		25a. REC'D BY REGISTRAR <b>MAR 21 '62</b>	
ADDRESS <b>30 H Street, N.E.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03582 Item 13 Infor. from birth certificate 03586											
1. PLACE OF DEATH a. COUNTY <b>prince George</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY in lb <b>2 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>66 East River Dale</b>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>						d. STREET ADDRESS <b>6237 64 Ave</b>					
3. NAME OF DECEASED (Type or print) <b>Coborn</b>						4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 23 1962</b>		9. AGE (In years last birthday) yrs. <b>45</b> Months <b>4</b> Days <b>48</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>48</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Chester Henry Coborn</b>						14. MOTHER'S MAIDEN NAME <b>Carol Jean Larson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mother</b>		Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Bilateral Pulmonary</b> <b>754.2</b> DUE TO <b>2. Congenital Heart Disease (Ventricular septal)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3. Prematurity</b> DUE TO (c) <b>atelectasis</b> <b>xx Congenital Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 19 <b>62</b> to <b>3-25</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>3-25</b> , 19 <b>62</b> , and that death occurred at <b>12:40</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John W. Perkins</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/>		P.M. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/25/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins</b>						22d. ADDRESS <b>5301 Hamilton St., Hyattsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3-31-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>		23d. LOCATION (City, town or county) <b>Cheverly, Maryland</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Perkins, Jr., Administrator</b>						25a. REC'D BY REGISTRAR <b>APR 3 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

2-046104



0117 22-15-5 150000  
2 + 100000 200000 100000

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03593

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03587

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sylvester Nathaniel Coleman</b>			4. DATE OF DEATH Month Day Year <b>March 10 19 62</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1940</b>		9. AGE (In years last birthday) <b>22</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>L aborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>	11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Nathaniel Coleman</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Gertrude Warner</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-36-2861</b>	17. INFORMANT <b>Elizabeth G. Warner, same as # 2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage 2nd shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>LACERATION OF AORTA</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Head on automobile collision</b>			
20c. TIME OF INJURY Month, Day, Year <b>1:49 a.m. xxx 3/10/ 19 62</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) <b>Bowie</b>	(County) <b>P. G.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/10/62</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-14-62</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Family</b>		22d. LOCATION (City, town, or country) (State) <b>Woodmore Md</b>	
23. FUNERAL DIRECTOR <b>Henry Washington</b>			24a. REC'D BY REGISTRAR <b>MAR 15 '62</b>		
ADDRESS <b>4925 Dean Ave NE DC</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03594

03588

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN b. <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <b>b. COUNTY</b> <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15x-2</u> d. STREET ADDRESS <u>1000 Daleview Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>DORA REAVILL COOK</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10/7/1869</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>92</u> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Illinois</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>4. DATE OF DEATH</b> <u>March 13</u> 19 <u>62</u> Month Day Year <b>13. FATHER'S NAME</b> <u>Andrew J. Reavill</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Reavill</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Harold T Cook</u> Address <u>Washington D C</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> (b) <u>Coronary thrombosis</u> (c) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>4 hours</u> <u>year</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb.</u> <u>1962</u> <u>to</u> <u>3-13</u> <u>1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3-13</u> <u>1962</u> <b>and that death occurred at</b> <u>1:00 P.M.</u> <b>from the causes and on the date stated above</b>			
<b>22a. SIGNATURE</b> <u>Donald C. Edgren</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>DONALD C. EDGREN</u>		<b>22b. DATE SIGNED</b> <u>3-13-62</u> <b>22d. ADDRESS</b> <u>HYATTSVILLE, Maryland</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u> <b>23b. DATE THEREOF</b> <u>3/16/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Colmar Manor, Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis Gasch's Sons</u> <b>ADDRESS</b> <u>Hyattsville, Maryland</u> <b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 19 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b>	



1934

1934

1934

1934

U.S.A.

Owensboro

Honolulu

County of Honolulu

County of Honolulu

County of Honolulu

County of Honolulu

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County of Honolulu

County of Honolulu



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03595

## CERTIFICATE OF DEATH

03589

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY in 1b <b>30 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5512 43rd Place</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>63 Hyattsville,</b> d. STREET ADDRESS <b>5512 43rd Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARGARET</b>		<b>First</b>		<b>Middle</b>		<b>Last</b>		<b>4. DATE OF DEATH</b> <b>March 15, 1962</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 8, 1876</b>		<b>9. AGE</b> (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>England</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>England</b> ✓			
<b>13. FATHER'S NAME</b> <b>John Cullen</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary McPartlan</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>Austin J. Cullen same as #2 (Brother)</b> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>arter Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary thrombosis</b> (e), stating the underlying cause last. DUE TO <b>arteriosclerotic heart disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>11</b> <b>years</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1958</b> <b>to</b> <b>3-15</b> , <b>1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>3-15</b> , <b>1962</b> , <b>and that death occurred at</b> <b>10 A.M.</b> , <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Donald C. Edgren</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DONALD C. EDGREN</b>				<b>22d. ADDRESS</b> <b>Hyattsville, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/19/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ft. Lincoln</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Colmar Manor, Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis Gasch's Sons</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>MAR 19 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanna</b>			

(M)

(A)

08588

08588

Francis Scott

Francis Scott

Hyattsville

Hyattsville

3212 43rd Place

3212 43rd Place

MARGARET

CULLEN

Female White

1878

Hyattsville

Hyattsville

Own Home

John Cullen

Mary McFarland

none

no

Annie J. Cullen same as above (sister)

Francis Scott

Francis Scott

Hyattsville, Md.

Hyattsville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03596  
CERTIFICATE OF DEATH  
03590

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>6908 Annapolis Road</b>	
3. NAME OF DECEASED (Type or print) <b>Helen M Daigle</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1884</b>
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Smith</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Jewett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Benjamin J. Dorgle Same as #2</b>	
17. INFORMANT <b>Benjamin J. Dorgle Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebro vascular thrombosis with left hemisphere</b> DUE TO (b) <b>cerebral arteriosclerosis</b> DUE TO (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>11 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Myocardial infarction</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Nov. 1st, 1957, Haver 2nd, 1962</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1st, 1957</b> to <b>Mar 2nd, 1962</b> , that (I) (we) last saw the deceased alive on <b>Mar 1st, 1962</b> , and that death occurred at <b>3:00AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Dr. Teil Bergemann</b> M.D.	
22b. DATE SIGNED <b>2 Mar 62</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Teil Bergemann M.D.</b>	
22d. ADDRESS <b>53 A Crescent Road Greenbelt., Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/3/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasoh's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
25a. REC'D BY REGISTRAR <b>MAR 5 62</b>		25b. REGISTRAR'S SIGNATURE <b>Conrad E. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the General Director's Office should be detached for use as the burial-transit permit. Then please remove carbon papers.  
The registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03597

CERTIFICATE OF DEATH

Reg. Dist. No. 03591

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Prince George</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRIDGE 3, Box 266</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, Md. Aft 5, Box 266</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Davis</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1890</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retiree</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>	
13. FATHER'S NAME <u>Frederick Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Gilberta Slater - Brandywine, Md.</u>		Address <u>—</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis and atherosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 17, 1962</u> , 19 <u>55</u> , to <u>March 17, 1962</u> , that I last saw the deceased alive on <u>March 17, 1962</u> , and that death occurred at <u>7:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard D. Hal Dobson</u> M.D.		DATE SIGNED <u>Brandywine, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Richard D. Hal Dobson</u>		<u>Brandywine, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/22/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>	22d. LOCATION (City, town, or county) (State) <u>Aquasco, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Kelson</u> ADDRESS <u>Aquasco, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>	





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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 and 6 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A13ME  
5M 1/62

03598  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
03592

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN b. <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Massachusetts</b> b. COUNTY <b>Jamaica Plains</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3302 Washington Street</b> d. STREET ADDRESS <b>3302 Washington Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Francis William Donald</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7th.</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18th., 1922</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Exercise Boy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Race Track</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Alexander Donald</b>		14. MOTHER'S MAIDEN NAME <b>Ola Beatrice Ready</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Vivian Black</b>		Address <b>So. Boston, Mass. 170 L. Street,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of skull &amp; left knee</b> Conditions, if any, which gave rise to immediate cause (b) <b>8-23 X</b> (c) <b>8-23 X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Passenger in automobile that ran off road</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in automobile that ran off road</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:40 p.m. Mar. 7, 1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.) <b>Route 197</b>		20f. (City or town) (County) (State) <b>Laurel P.G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James L. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES L. BOYD, M.D.</b>		DATE SIGNED <b>3/8/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-14-1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or country) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co., Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 15 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>William L. House</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
03599					03593														
Items 11 & 12 Film G309 3/15/62 iwk																			
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>01 Laurel</b> d. STREET ADDRESS <b>103 Main Street</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print) <b>James</b> First Middle Last <b>James Dorsey</b>					<b>4. DATE OF DEATH</b> <b>March 2 19 62</b> Month Day Year														
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>About 1883</b>		<b>9. AGE</b> (In years last birthday) <b>79 7 yrs.</b>											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Groom</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Race Horse Track</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Unknown Ireland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>													
<b>13. FATHER'S NAME</b> <b>Patrick Dorsey</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>														
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Unknown</b> (If yes give year or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> <b>Hosp.</b> Address												
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3 2 1 X</b> DUE TO <b>CVA - Cerebral vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH																			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>					<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)					<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Feb. 25</b> <b>19. 62</b> <b>to</b> <b>March 2</b> <b>19. 62</b> <b>that (I) (we) last saw the deceased alive on</b> <b>March 2</b> <b>19. 62</b> <b>and that death occurred at</b> <b>2.25 A</b> <b>from the causes and on the date stated above.</b>										<b>22a. SIGNATURE</b> <b>Albert Roth</b> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>P.M. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <b>3-3-62</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Albert Roth</b>					<b>22d. ADDRESS</b> <b>5510 Madison St., Riverdale, Md.</b>														
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>					<b>23b. DATE THEREOF</b> <b>3/8/62</b>					<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Cemetery</b>					<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Md.</b>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Vernon Lemmon</b>					<b>ADDRESS</b> <b>4611 Park Heights. Balto.</b>					<b>25a. REC'D BY REGISTRAR</b> <b>MAR 8 '62</b>					<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Finner</b>				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove card 3 and 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03600

CERTIFICATE OF DEATH

03594

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b> c. LENGTH OF STAY in 1b <b>8 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>01 Laurel</b> d. STREET ADDRESS <b>28 Arondale St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>a</b> Middle <b>DOVET</b> Last		4. DATE OF DEATH <b>Mar 20</b> Month <b>1962</b> Year					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 13, 1915</b> 46 yrs.	9. AGE (in years last birthday) <b>46</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RACE TRACK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HORSE GROOM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>St Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOSEPH DOVET</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>401-19-0553</b>
17. INFORMANT <b>BLANCHE DOVE</b> Address <b>28 Arondale St Laurel</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung.</b> 163X Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2/20</b> , 19 <b>61</b> , to <b>3/20</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/20</b> , 19 <b>62</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>B P Warren</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Laurel md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<b>Burial</b>	<b>3/23/62</b>	<b>Ory Hill</b>		<b>Laurel md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ridgley Seely</b>		ADDRESS <b>5024th St Laurel md</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 28 '62</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>		d. STREET ADDRESS <u>6104 A Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Beland Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alva</u> Middle <u>houise</u> Last <u>Dowe</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-17</u> <u>44</u> yrs.	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Maurice Milburn</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Dove</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year and dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>31-12-0251</u> INFORMANT <u>Hospital Record</u> Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus.</u>							
626x } DUE TO <u>Cardiac Decomp / Lobar Pneumonia</u> 2 days							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Pelvic Peritonitis - Ruptured Left Fallopian Tube</u> 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>15 March</u> , 1962 to <u>21 March</u> , 1962 that (I) (we) last saw the deceased alive on <u>21 March</u> , 1962, and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas M. Hutchins</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-21-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS M. HUTCHINS</u>				22d. ADDRESS <u>7315 Landover Rd Hyattsville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-26-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM</u>		23d. LOCATION (City, town or county) <u>SUITLAND</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>Riverdale, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 27 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

03205

LETTERS OF THE

10000



11-12-19

at the door

Marice Hillman

My dear Marice

I am so glad to hear

from you and hope you are

well and happy as ever

I am so glad to hear

from you

Yours truly

Marice Hillman

Marice Hillman

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3, should be retained for your files. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/62

## MARYLAND STATE DEPARTMENT OF HEALTH STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>04 Bowie</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>1 8th and Maple Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dwayne</b> Middle <b>Michael</b> Last <b>Duckett</b>		4. DATE OF DEATH <b>March 11 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1961</b>
9. AGE (In years last birthday) <b>3 2</b> yrs		IF UNDER 1 YEAR <b>3 2</b> Months <b>2</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ivory Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Duckett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Evelyn Duckett, same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (b) <b>493X</b> (c) <b>493X</b> (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/11/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-15-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM. CEMETERY SUITLAND, MD.</b>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>John T. Rhines &amp; Co. 3015-12th St. N.W. D.C.</b>		24a. REC'D BY REGISTRAR <b>15 62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rhines</b>		DATE <b>MAR 15 '62</b>	

MEDICAL CERTIFICATION

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11-012318

(M)

03258

Prince George's

University

College

Prince George's General Hospital

St. and North Avenue

George

Michael

Robert

X

Colonel

John

Dr. G. L. I.

John

John

Myland

Ivory Cooper

Everett Tucker

John

Swain Tucker, and as

Insurance

X

James I. Boyd

James I. Boyd

James I. Boyd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, who is to be filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No. 03597

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hasbrouck Heights</u>		<u>67X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suitland Nursing Home</u>				d. STREET ADDRESS <u>257 Walton Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Levi's</u> Middle <u>Eckerfelder</u> Last <u>Eckerfelder</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 62</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/1874</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Eckenfelder</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Meyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>S. Thomson Eckenfelder Washington 27, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 5, 1962</u> to <u>Mar 9, 1962</u> , that I last saw the deceased alive on <u>Mar 9, 1962</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Thibadeau</u>				DATE SIGNED <u>3/12/62</u>			
PHYSICIAN'S NAME (Type) <u>J. H. Thibadeau</u>				<u>Washington D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-13-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASHINGTON MEM. PK</u>		22d. LOCATION (City, town, or county) (State) <u>PARAMUS, NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Early Perewich</u>				ADDRESS <u>Pyndale Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

CERTIFICATE OF DEATH

1913

(M)

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15, 1868		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN	
Clerk		Heart Disease		Home		10:30 AM		J. H. Harris	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
16. SIGNATURE OF DEPUTY CLERK		17. SIGNATURE OF DEPUTY CLERK		18. SIGNATURE OF DEPUTY CLERK		19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
21. SIGNATURE OF DEPUTY CLERK		22. SIGNATURE OF DEPUTY CLERK		23. SIGNATURE OF DEPUTY CLERK		24. SIGNATURE OF DEPUTY CLERK		25. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
26. SIGNATURE OF DEPUTY CLERK		27. SIGNATURE OF DEPUTY CLERK		28. SIGNATURE OF DEPUTY CLERK		29. SIGNATURE OF DEPUTY CLERK		30. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
31. SIGNATURE OF DEPUTY CLERK		32. SIGNATURE OF DEPUTY CLERK		33. SIGNATURE OF DEPUTY CLERK		34. SIGNATURE OF DEPUTY CLERK		35. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
36. SIGNATURE OF DEPUTY CLERK		37. SIGNATURE OF DEPUTY CLERK		38. SIGNATURE OF DEPUTY CLERK		39. SIGNATURE OF DEPUTY CLERK		40. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
41. SIGNATURE OF DEPUTY CLERK		42. SIGNATURE OF DEPUTY CLERK		43. SIGNATURE OF DEPUTY CLERK		44. SIGNATURE OF DEPUTY CLERK		45. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
46. SIGNATURE OF DEPUTY CLERK		47. SIGNATURE OF DEPUTY CLERK		48. SIGNATURE OF DEPUTY CLERK		49. SIGNATURE OF DEPUTY CLERK		50. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
51. SIGNATURE OF DEPUTY CLERK		52. SIGNATURE OF DEPUTY CLERK		53. SIGNATURE OF DEPUTY CLERK		54. SIGNATURE OF DEPUTY CLERK		55. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
56. SIGNATURE OF DEPUTY CLERK		57. SIGNATURE OF DEPUTY CLERK		58. SIGNATURE OF DEPUTY CLERK		59. SIGNATURE OF DEPUTY CLERK		60. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
61. SIGNATURE OF DEPUTY CLERK		62. SIGNATURE OF DEPUTY CLERK		63. SIGNATURE OF DEPUTY CLERK		64. SIGNATURE OF DEPUTY CLERK		65. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
66. SIGNATURE OF DEPUTY CLERK		67. SIGNATURE OF DEPUTY CLERK		68. SIGNATURE OF DEPUTY CLERK		69. SIGNATURE OF DEPUTY CLERK		70. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
71. SIGNATURE OF DEPUTY CLERK		72. SIGNATURE OF DEPUTY CLERK		73. SIGNATURE OF DEPUTY CLERK		74. SIGNATURE OF DEPUTY CLERK		75. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
76. SIGNATURE OF DEPUTY CLERK		77. SIGNATURE OF DEPUTY CLERK		78. SIGNATURE OF DEPUTY CLERK		79. SIGNATURE OF DEPUTY CLERK		80. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
81. SIGNATURE OF DEPUTY CLERK		82. SIGNATURE OF DEPUTY CLERK		83. SIGNATURE OF DEPUTY CLERK		84. SIGNATURE OF DEPUTY CLERK		85. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
86. SIGNATURE OF DEPUTY CLERK		87. SIGNATURE OF DEPUTY CLERK		88. SIGNATURE OF DEPUTY CLERK		89. SIGNATURE OF DEPUTY CLERK		90. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
91. SIGNATURE OF DEPUTY CLERK		92. SIGNATURE OF DEPUTY CLERK		93. SIGNATURE OF DEPUTY CLERK		94. SIGNATURE OF DEPUTY CLERK		95. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
96. SIGNATURE OF DEPUTY CLERK		97. SIGNATURE OF DEPUTY CLERK		98. SIGNATURE OF DEPUTY CLERK		99. SIGNATURE OF DEPUTY CLERK		100. SIGNATURE OF DEPUTY CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03598

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.C.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>52 College Park, Mobile Homes</b> <b>1 4 5th Street</b>	
3. NAME OF DECEASED (Type or print) <b>Louis John</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug, 31, 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. Government Missouri</b>	
13. FATHER'S NAME <b>Louis J. Ehrler</b>		14. MOTHER'S MAIDEN NAME <b>Lottie UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Etna Marie Esrich, Washington D.C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Myocardosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Cirrhosis of the liver</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>3/20/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-23-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem -</b>		22d. LOCATION (City, town, or country) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR <b>W. W. Chambers Co</b>		24e. REC'D BY REGISTRAR <b>MAR 23 '62</b>	
ADDRESS <b>Riverdale, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03605

03599

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Helant Memorial</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>65 Riverdale</u> d. STREET ADDRESS <u>4811 Riverdale Road Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth M. Eshelbrenner</u>		4. DATE OF DEATH <u>March 24 1962</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1877</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George Humphreville</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Glazier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Robert E. Eshelbrenner Same as #2 (son)</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY ARTERIO-SCLEROTIC HEART DISEASE 10 yrs.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>CHRONIC CONGESTIVE HEART FAILURE</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>3-23-</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3-23-</u> , 19 <u>62</u> , and that death occurred at <u>1500</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Albert H. Noel, MD</u>		22b. DATE SIGNED <u>3/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Albert H. Noel, MD</u>		22d. ADDRESS <u>550 Madison St. Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/28/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	23d. LOCATION (City, town or county) (State) <u>Lancaster Pa.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1962</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

0559

CERTIFICATE OF DEATH

0559

1

George Humphreys  
Hampshire  
Born 10/10/1875  
Died 10/10/1875  
U.S.A.  
Margaret Graham

Robert E. Humphreys  
Hampshire  
Born 10/10/1875  
Died 10/10/1875  
U.S.A.  
Margaret Graham

Charles (Charles) Humphreys  
Hampshire  
Born 10/10/1875  
Died 10/10/1875  
U.S.A.  
Margaret Graham

1  
FOR STATE  
HEALTH DEPT.

03606

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03600

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>			
c. LENGTH OF STAY IN 1b <b>DOA</b>				d. STREET ADDRESS <b>3704 35th Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Guy</b>		First Middle Last <b>Farson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 25, 78</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Farson</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Virginia Young</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>5-7705-7011a</b>		17. INFORMANT <b>Mrs Elsie A. Martin, Baltimore, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b>							
DUE TO (b) <b>Cardiovascular renal disease</b>							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 25, 1962</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/28/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
23. FUNERAL DIRECTOR <b>Kalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 30 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





13  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03607 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03601

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Albert Herman Fenrich</b>				4. DATE OF DEATH <b>March 1, 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 20, 1905</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13. FATHER'S NAME <b>Fred Fenrich</b>				14. MOTHER'S MAIDEN NAME <b>Marie Lubenow</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 11 473-09-9034</b>			
17. INFORMANT <b>Eleanor Katherine Fenrich, same as # 2</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>							
DUE TO (b) <b>Coronary artery disease</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20e. (City or town)				20f. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>3/1/62</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/4/62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Burtonsville Md.</b>			
23. FUNERAL DIRECTOR <b>De Witt Canadahan, Laurel Md.</b>				24. REC'D BY REGISTRAR <b>Charles E. Krause</b>			
ADDRESS				DATE <b>7 '62</b>			

MEDICAL CERTIFICATION

10301

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03608

CERTIFICATE OF DEATH

03602

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b>	
c. LENGTH OF STAY IN 1b <b>3 days</b>		d. STREET ADDRESS <b>8402 Manchester Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Geraldine M Fitez</b>		4. DATE OF DEATH Month Day Year <b>March 18 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 July 1906</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN DAVID FITEZ</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE B. STAMBAUGH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-38-3298</b>	
17. INFORMANT <b>Mrs. Christopher DeFrancisci</b>		Address <b>931 Ray Rd. Hyatts. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>2h Cerebral infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/18/62</b> to <b>3/18/62</b> that (I) (we) last saw the deceased alive on <b>3/18/62</b> and that death occurred at <b>2:30AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Leon Levitsky</b>		22b. DATE SIGNED <b>3-20-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Leon Levitsky., M.D.</b>		22d. ADDRESS <b>3408 R.I. Ave. Mt Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-21-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>THURMONT MARYLAND</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		25a. REC'D BY REGISTRAR <b>20 MAR 20 '62</b>	
ADDRESS <b>WASH. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
<b>FRANCIS J. COLLINS 3821 14TH. ST. N.W.</b>			

VR A15 (4)

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Prince George

Chesley

2 days

Silver Spring

James Gordon General Hospital

2000 Washington Road

Washington

Street

March 19

Thomas Wills

14 July 1908

Teacher

SCHOOL

WALTON

U. S. A.

JOHN DAVID WHITE

MINNIE STAMBAUGH

501 E. W. Street, W.

577-38-388 Mrs. Christopher Thompson

to

*Handwritten signature*

Burial 3-21-08

High Cemetery THOMONT

FRANCIS A. COLLINS 3821 14TH ST. N.W.

2406 E. 14th St. N.W. W. D. D. D.

2-10-08

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FOR STATE HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03609

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03603

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 110 Leslie Avenue	
3. NAME OF DECEASED (Type or print) Philip		4. DATE OF DEATH March 29th, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 4, 1899	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Radio-television Poland	
11. CITIZEN OF WHAT COUNTRY? U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Flagman		14. MOTHER'S MAIDEN NAME Jennie Rudolph	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-7845	
17. INFORMANT Helen Frances Flagman, same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last, (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes since 1951			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 3/29/62			
21. ACTUAL SIGNATURE James I. Boyd			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF April 2, 1962			
22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			
22d. LOCATION (City, town, or country) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR ADDRESS Sol. Levinson & Bros Inc. 6080 Reisterstown Road			
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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33-4416-1021A-1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the death certificate is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03610

CERTIFICATE OF DEATH

03604

Item 3 Film G309 3/20/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1520 Sandy Spring Rd.</u>		d. STREET ADDRESS <u>1520 Sandy Spring Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Anna Gaigley</u>		4. DATE OF DEATH <u>March 11 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 1889</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>	
13. FATHER'S NAME <u>John N. Gaigley</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Mayer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1520 Sandy Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Chronic Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 mo.</u> <u>10 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> <u>10</u> <u>1962</u> e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> <u>1961</u> to <u>3/10</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>3/10</u> <u>1962</u> and that death occurred at <u>11/4</u> <u>1962</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cem</u>		23d. LOCATION (City, town or county) (State) <u>Laurel Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Davidson</u>		25e. REC'D BY REGISTRAR <u>16 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>Robert A. Davidson</u>		25c. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03611 CERTIFICATE OF DEATH 03605

1. PLACE OF DEATH e. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> c. LENGTH OF STAY IN 1b <u>3 1/2 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SOUTHERN MARYLAND HOSPITAL CENTER</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>ALLEGHENY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEGIE</u> d. STREET ADDRESS <u>528 CHESTNUT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>JAMES GRAHAM GAMBLE</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>MARCH 28 1962</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/15/87</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Day Hours Min.		11. IF UNDER 24 HRS. Months Day Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COUNTY PROPERTY ASSESSOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>COUNTY GOVT.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>ALLEGHENY, PA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>JAMES G. GAMBLE</u>				14. MOTHER'S MAIDEN NAME <u>LIZZIE MILLAR</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>SON JAMES GAMBLE</u>				17. INFORMANT <u>PINEVIEW LANE CLINTON MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>157X INANITION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF THE BODY OF THE PANCREAS WITH GENERALIZED METASTASES</u> (c) <u>COMMON</u>																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>																					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u>																	
20d. INJURY OCCURRED While at work Not While at work <u>None</u>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>				20f. (City or town) (County) (State) <u>None</u>													
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1961</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>MAR 27 1962</u> and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.																					
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.								22b. DATE SIGNED <u>3/28/62</u>				22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>									
22d. ADDRESS <u>BRANCH AVE, CLINTON, MD.</u>								23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								23b. DATE THEREOF <u>Mar 31-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Charter's Cemetery Carnegie, Pa.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros 1661-94 Hopi Rd</u>								25a. REC'D BY REGISTRAR <u>APR 2 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Shaver</u>									

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3, should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03612

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03606

1. PLACE OF DEATH e. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine - Rural		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf 08X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dobson Clinic				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carlton Edward Garner				4. DATE OF DEATH Month Day Year March 30, 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1905	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Garner				14. MOTHER'S MAIDEN NAME Jane Williams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 216-10-5350		17. INFORMANT Address Elsie Wilmer, Faulkner, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute congestive heart failure DUE TO (b) Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) March 31, 1962							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-62		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or country) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR ADDRESS The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR APR 3 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03613

## CERTIFICATE OF DEATH

03607

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 478-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 503 L. St., N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary - Gates		4. DATE OF DEATH Month 3 Day 25 Year 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/1882?
9. AGE (In years last birthday) 79? yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Boatman, caseworker		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis; rectal stricture due to lymphopathia venereum; chronic pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/19/62 to 3/25/62, that (I) (we) last saw the deceased alive on 3/25/1962, and that death occurred at 2 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 3/25/62	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-30-1962	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (City, town or county) (State) Huntville, Md.
24. FURNAL DIRECTOR'S SIGNATURE Moe Weiss		25a. REC'D BY REGISTRAR MAR 29 62 25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

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Wm. H. Hall

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03614

03608

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges County</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>	
c. LENGTH OF STAY IN 1b <b>45 Days</b>		d. STREET ADDRESS <b>14 Z Ridge Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Louis Gerstel</b>		4. DATE OF DEATH <b>March 25, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-90</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Collector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Clothing</b>	11. BIRTHPLACE (County & State, or foreign country) <b>England</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13. FATHER'S NAME <b>Michael Gerstel</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Weissbroth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-03-7792</b>	
17. INFORMANT <b>Lilian Gerstel</b>		Address <b>14 Z Ridge Rd., Greenbelt Md.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>196.7</b> DUE TO <b>Angiosten heart failure x.c. to arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Diast. Disease w/ sarcomatous degeneration</b> (a), stating the underlying cause last. } DUE TO <b>sarcoma of left femur with metastases</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 p</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from <b>February 9, 1962</b> to <b>March 25, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 25, 1962</b> , and that death occurred at <b>6:55 P.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Dr. Madarang</b> M.D.	22b. DATE SIGNED <b>3-26-62</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. Madarang</b>	22d. ADDRESS <b>Prince George's General Hosp., Cheverly, Md</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/27/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Mem. Park</b>	23d. LOCATION (City, town or county) (State) <b>Falls Church, Va.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Jones</b>		25a. REC'D BY REGISTRAR <b>MAR 28 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03615 Item 9 Film G310 4/2/62 mh											
03609											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b> c. LENGTH OF STAY IN lb <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS WASH 25</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>20 SUTLAND</b> d. STREET ADDRESS <b>4819 SUTLAND ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>GEORGE (NMI) GORDON</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>1962</b>			5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>22 APR 1915</b>			9. AGE (In years last birthday) <b>47 yrs</b>			IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET- ARMY CWO</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>			11. BIRTHPLACE (County & State, or foreign country) <b>SOUTH HADLEY FALLS, MASS</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>OLIVER GORDON (DECEASED)</b>						14. MOTHER'S MAIDEN NAME <b>ADELE (NATTIE) GORDON MORIN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES KOREAN</b>						16. SOCIAL SECURITY NO. <b>---</b>					
17. INFORMANT <b>MRS. JUNE GORDON, 4819 SUTLAND RD, SUTLAND MD</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> 9 03 00 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Traumatic pneumothorax R, RLL pneumonia + septicemia</b> 24 hrs (c) <b>Traumatic fracture of Ribs 6 &amp; 7</b> 24 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>1) Cirrhosis - advanced; 2) Delirium Tremens - convulsions 3) Oliguria</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)</b> <b>Tripped &amp; fell striking chest while walking to dining room.</b> 20c. TIME OF INJURY Month, Day, Year <b>22 Mar 1962</b> Hour e.m. <b>8:00</b> p.m. <b>19 62</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) <b>Sutland</b> (County) <b>Prince Georges</b> (State) <b>Md.</b> 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>23 March, 1962</b> to <b>24 March, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>24 March, 1962</b> and that death occurred at <b>10:20 PM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>William K. Grove Capt USAF MC</b> M.D. 22b. DATE SIGNED <b>24 Mar 1962</b> 22c. PHYSICIAN'S NAME (Type) <b>WILLIAM K GROVE, Capt USAF MC</b> 22d. ADDRESS <b>USAF HOSP, ANDREWS AIR FORCE BASE, MD</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>Mar. 29, 1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Virginia</b> 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. CHAMBERS CO.</b> ADDRESS <b>517 11th St SE Wash. D.C.</b> 25. REC'D BY REGISTRAR <b>MAR 29 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>											

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WILLIAM K. CROFT, CHIEF, U.S. MARSHAL SERVICE, WASHINGTON, D.C.

W. W. CHAMBERS CO.

RECEIVED MAY 24 1944

STATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

03615

03610

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 1560-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 9807 River Road	
3. NAME OF DECEASED (Type or print) First Middle Last Clara HALL Gordy		4. DATE OF DEATH Month Day Year March 20 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Sept. 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ELISHA HALL	
14. MOTHER'S MAIDEN NAME HENRIETTA JARMAN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS RUTH MULLIKIN 7601 WALTERS LANE DISTRICT HHTS, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure (b) Arterio Sclerotic Cardiac Vascular Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 3-16 to 3-20, 1962, that (I) (we) last saw the deceased alive on 3-20 1962, and that death occurred at 12:05AM from the causes and on the date stated above.	
22a. SIGNATURE Benjamin S. Peason M.D.		22b. DATE SIGNED 3-21-62	
22c. PHYSICIAN'S NAME (Type) Dr. Benjamin S. Peason		22d. ADDRESS 7018 Malboro Pike, Dist Hght Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-23-1962	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) BLADENSBURG, MD	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co, Riverdale, Md		25a. REC'D BY REGISTRAR DATE MAR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03617  
03611

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 31 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aquasco d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Gray First Middle Last		4. DATE OF DEATH March 28 19 62 Month Day Year	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 18 75 9. AGE (In years last birthday) 86 87 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Pr. Geo's Co. Maryland
13. FATHER'S NAME Edward Benjamin Gray		14. MOTHER'S MAIDEN NAME Joanna Douglass	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Delphinia Gray Aquasco, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) B bronchopneumonia (b) A S C V D (c) Senility Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 62 Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/28 to 3/28 19 62, that (I) (we) last saw the deceased alive on 3/28 19 62, and that death occurred at 2:00 PM from the causes and on the date stated above.			
22a. SIGNATURE David S. Clayman M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. David S. Clayman		22d. ADDRESS 6311 Baltimore Ave., Riverdale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/31/62	23c. NAME OF CEMETERY OR CREMATORY John Wesley	23d. LOCATION (City, town or county) (State) Aquasco, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE George G. Nelson		25a. REC'D BY REGISTRAR DATE 3/29/62 25b. REGISTRAR'S SIGNATURE Arthur S. Haines	

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EXHIBIT A-2

63813



*[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

BP

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03618						03612							
1. PLACE OF DEATH e. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>44 Cottage City</b> d. STREET ADDRESS <b>3703 40th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Baby Girl</b>			First Middle Last <b>Greer</b>			4. DATE OF DEATH Month Day Year <b>March 12 1962</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>3-10-62</b>		9. AGE (In years last birthday) yrs. Months Days <b>1 13 40</b>		IF UNDER 1 YEAR Months Days <b>1 13 40</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>					
13. FATHER'S NAME <b>Earl Greer</b>						14. MOTHER'S MAIDEN NAME <b>Bobbie Louise Wilson</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number and date of service)		17. INFORMANT Address <b>Mother Same as above</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Bilateral Pulmonary Atelectosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>(2) Prematurity</b> DUE TO <b>(3) Cephalohematoma</b>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		Month, Day, Year <b>3/11/62</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>West Hyattsville, Md.</b>		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3/11/62</b> to <b>3/12/62</b> , that (I) (we) last saw the deceased alive on <b>3/11/62</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above.													
22e. SIGNATURE <b>Barry Rosenberg</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. Barry Rosenberg</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/12/62</b>					
22d. ADDRESS <b>1210 Chillum Manor Rd., West Hyattsville, Md.</b>													
23e. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3-19662</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>				23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b>						25e. REC'D BY REGISTRAR DATE <b>MAR 21 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Christina S. Kraus</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03619 CERTIFICATE OF DEATH 03613

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>20 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>46 Brentwood</b> d. STREET ADDRESS <b>3804 Windom Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gladys E. Hamilton</b>			4. DATE OF DEATH Month Day Year <b>March 13 1962</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11-12-1900</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Dept. Store in Grand Island</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grand Island, Neb.</b>		11. BIRTHPLACE (City, County & State, or foreign country) <b>North Platte, Nebraska</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Guy Bush</b>			
14. MOTHER'S MAIDEN NAME <b>Gertrude Anna Reed</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>506-28-845</b>			
16. SOCIAL SECURITY NO. <b>506-28-845</b>		17. INFORMANT <b>Guy Kent Hamilton</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Fibrinous pericarditis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Mitral stenosis</b> DUE TO <b>Chronic Rheumatic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 month</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lobar pneumonia (left upper lobe--causative organism undetermined)</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-1-62</b> to <b>3-13-62</b> , that (I) (we) last saw the deceased alive on <b>3-13-62</b> , and that death occurred at <b>1:25 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>David S. Clayman</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/13/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID S. CLAYMAN</b>		22d. ADDRESS <b>6311 Balto Ave - Riverdale Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/17/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	
23d. LOCATION (City, town or county)		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home,</b>		ADDRESS <b>1st. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 19 1962</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>					

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 66 East Riverdale	
c. LENGTH OF STAY IN lb 11 days		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 16317 Kenilworth Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 77 Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Estelle Harbaugh		4. DATE OF DEATH Month Day Year March 17 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1871
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Harbaugh		14. MOTHER'S MAIDEN NAME Mary Jane Warren	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 212-10-3293	
17. INFORMANT Charles Seay, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 4 500 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the left hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed	
20c. TIME OF INJURY Hour a.m. 8:00 p.m. 3/6/ 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) East Riverdale (County) P. G. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-1962	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or country) Baltimore, (State) Md.	
23. FUNERAL DIRECTOR G. Howard Strong		24a. REC'D BY REGISTRAR DATE MAR 20 '62	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b> c. LENGTH OF STAY IN tb <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>3917 Oliver Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Alexina Harrison Harris</b>						<b>4. DATE OF DEATH</b> Month Day Year <b>March 28 19 62</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 1, 1885</b>		<b>9. AGE</b> (In years last birthday) <b>76</b> yrs.		<b>IF UNDER 24 HOURS.</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Cassius Alexander Harrison</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Betty Devons</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Margaret Harris Tucker W. Lafayette, Indiana</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b> (e), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured left femur</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>3-14 19 62</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		<b>20f. (City or town)</b> <b>Hyattsville, P.G., Maryland</b>		(County) (State)	
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i> <b>M.D.</b> <b>EXAMINER'S NAME</b> (Type) <b>Dr. James I. Boyd</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>3-28-62</b> <b>Address</b> (Street, city, town, or county)					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>Mar 30, 1962</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Scottsville Cemetery</b>		<b>22d. LOCATION</b> (City, town, or country) (State) <b>Scottsville Virginia</b>			
<b>23. FUNERAL DIRECTOR</b> <b>F. Gasch's Sons Hyattsville, Md.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>APR 2 '62</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hume</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03622 CERTIFICATE OF DEATH 03616

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LAUREL SANITARIUM</u>				d. STREET ADDRESS <u>WINDSOR COURT Apts.</u>			
3. NAME OF DECEASED (Type or print) First <u>ABBIE</u> Middle <u>M.</u> Last <u>HARTPOVE</u>				4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 31-1878</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>LYMAN A. MEACHAN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Hosp. Records LAUREL SANITARIUM</u>				Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac infarction (420.)</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>  </u> (b) <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-12-1961</u> to <u>9-23-1962</u> that (I) (we) last saw the deceased alive on <u>3-23-1962</u> and that death occurred at <u>9:24</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Linda P. Kramer</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3-23-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAMER</u>				22d. ADDRESS <u>LAUREL SANITARIUM LAUREL MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickner &amp; Sons Inc Pa Ave 17</u>				25. REC'D BY REGISTRAR DATE <u>MAR 27 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03623

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03617

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY	
Prince George's		Maryland		Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Clinton		D.O.A.		12 Brandywine	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Clinton Medical Center		Lusby Lane			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		Month Day Year	
Margaret		Hawkins		March 12th. 1962	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Female		Colored			
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
July 15, 1900		61 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House work		At Home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Alfred Jackson		Mary Pinkney		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No				Patrick Elsworth Hawkins same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute pulmonary edema			
443x		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Congestive heart failure	
		DUE TO			
		(c)		Hypertensive heart disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
JAMES I. BOYD		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3/13/62	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
JAMES I. BOYD, M.D.		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
BURIAL		3-16-62		UNION BETHEL T.B. MARYLAND	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
MYRTLE K. ROLLINS		4339 HUNT PL, NE		MAR 15 '62	

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George J. Gentry  
D. J. Gentry  
D. J. Gentry

March 1972  
March 1972  
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03624

## CERTIFICATE OF DEATH

Reg. Dist. No. 03618

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mrs. May's Nursing Home</u>		d. STREET ADDRESS <u>5229 N. 5th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Alice</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S. of Am.</u>		13. FATHER'S NAME <u>Joseph Taylor</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Mcquire</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Bertha V. Kessler</u> Address <u>Riverside, Md.</u> <u>5807 Harrison Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>288.5</u> DUE TO (b) <u>Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>8 months</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large Cystic Goitre (7" diameter)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Feb. 23, 1962</u> to <u>March 10, 1962</u> , that I last saw the deceased alive on <u>March 9, 1962</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> M.D.		ADDRESS (Street, city or town, state) <u>4340 St. Barnabas Road (Marlow Heights, Md.)</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson, M.D.</u>		<u>Washington 20, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-13-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Flint Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Oakton, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>		24a. REC'D BY REGISTRAR <u>Riverside Md.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03625

## CERTIFICATE OF DEATH

03619

Items 2 &amp; 7 Film G308 3/12/62 iwk

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE, MD 39</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5005 -60th. Ave.</b>		d. STREET ADDRESS <b>5005-60th AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM DAVID HOLLENBACK</b>		4. DATE OF DEATH Month Day Year <b>MARCH 5 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>NOV 11, 1898</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED COALMINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MUSIC PA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MOOSIC PA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HOLLENBACK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>196-01-8584</b>		16. SOCIAL SECURITY NO. <b>MRS. JAMES NEARY</b>	
17. INFORMANT <b>MRS. JAMES NEARY</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>COR PULMONALE</b> DUE TO (c) <b>SILICOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>2 YEARS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER, 1960</b> to <b>MARCH, 1962</b> , that (I) (we) last saw the deceased alive on <b>3/4</b> 1962, and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James Duke</b>		22b. DATE SIGNED <b>3/5/62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/9/62</b>		23b. DATE THEREOF <b>3/9/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs</b>		23d. LOCATION (City, town or county) (State) <b>Scranton Pa</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. Hoffell</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 7 '62</b>	
ADDRESS <b>475 H ST NW</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

03019

03019



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03626

## CERTIFICATE OF DEATH

Reg. Dist. No.

03620

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 2, Box 80</b>				d. STREET ADDRESS <b>Rt. 2, Box 80</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Humphrey</b> Last <b>Hook IV.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1888</b>	9. AGE (In years last birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard H. Hook III</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Wells</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-2102</b>		17. INFORMANT <b>Mrs. Ida Beall Hook-Same as Item 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.0 Cerebric</b> DUE TO (b) <b>Cerebral Cecum</b> DUE TO (c) <b>Pre-disposed to liver</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>unk.</b> <b>unk.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1, 1961</b> , to <b>14 Mar, 1962</b> , that I last saw the deceased alive on <b>14 Mar, 1962</b> , and that death occurred at <b>9:30 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. B. Sasscer</b>				ADDRESS (Street, city or town, state) <b>Upper Marlboro, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M.D.</b>				DATE SIGNED <b>3/14/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/17/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Forestville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro</b>				24a. REC'D BY REGISTRAR <b>MAR 21 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the REGISTRAR'S SIGNATURE should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03627

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03621

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Carrollton				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 36 Carrollton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6010 84th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAVID DANIEL HORAN		4. DATE OF DEATH March 24 19 62		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Nov. 26, 1958		9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) FLORIDA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Daniel Horan				14. MOTHER'S MAIDEN NAME Loretta Mary Solack			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Robert D. Horan Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsive disorder Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Cerebral palsy (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		JAMES I. BOYD				DATE SIGNED 3/24/62	
EXAMINER'S NAME (Type)		JAMES I. BOYD				Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/1962		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR ADDRESS W.W.Chambers Co., Riverdale, Md.				24a. REC'D BY REGISTRAR DATE MAR 27 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

000001



*James J. [illegible]*

1930



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 2 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

VR A15ME  
SM 1/62

03628  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03622  
MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4658 Homer Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>Edgar</b> Last <b>Howell</b>			4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 62</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>APRIL 13, 1899</b>		
9. AGE (In years last birthday) <b>62</b> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OCEANOGRAPHER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't</b>		
11. BIRTHPLACE (State or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>ALBERT S. HOWELL</b>			14. MOTHER'S MAIDEN NAME <b>ELYDIA JUDGE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WAR I</b>			16. SOCIAL SECURITY NO. <b>090-03-4677</b>		
17. INFORMANT <b>MRS ALICE DAILEY</b>			Address <b>139 FOREST ROAD FANWOOD NEW JERSEY.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b>					
Conditions, if any, which gave rise to immediate cause (b) <b>490X</b>					
(a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>James I. Boyd</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>3-21-1962</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, MARYLAND</b>			24a. REC'D BY REGISTRAR <b>MAR 23 '62</b>		
			24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		

DATE SIGNED  
**3/16/62**

US888

8888

Office of the Secretary of the Navy

Washington, D.C.

April 1, 1917

Mr. J. M. Smith

1000 Broadway

New York, N.Y.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

John D. Long

Secretary of the Navy

Enclosure

Very truly yours,

John D. Long

Secretary of the Navy

Enclosure

1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03629											
1. PLACE OF DEATH a. COUNTY Prince George's					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxon Hill					c. LENGTH OF STAY in lb 2 years						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4907 Forest Drive					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Howard Clifford Hunt					4. DATE OF DEATH March 10 1962						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1908		9. AGE (in years last birthday) 53 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radar technician		10b. KIND OF BUSINESS OR INDUSTRY Communication		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Clifford Patrick Hunt					14. MOTHER'S MAIDEN NAME Jennie Watkins						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no					16. SOCIAL SECURITY NO. no						
17. INFORMANT Eileen Dorothy Hunt, same as # 2					Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure											
DUE TO (b) Arteriosclerotic heart disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Rheumatic heart disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) James I. Boyd					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/10/62						
					DATE SIGNED						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Mar 13-62		22c. NAME OF CEMETERY OR CREMATORY Wash. National		22d. LOCATION (City, town, or country) (State) Southard Md		
23. FUNERAL DIRECTOR Simmons Bros					ADDRESS 1661-gd Hyattsville Wash DC					24e. REC'D BY REGISTRAR DATE MAR 13 '62	
					24b. REGISTRAR'S SIGNATURE Arthur L. Thomas						

MEDICAL CERTIFICATION



UNCLASSIFIED

MINISTRE DES AFFAIRES INDIENNES ET DU DEVELOPPEMENT REGIONAL

INDIAN AFFAIRS

Indian Affairs

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FOR STATE  
HEALTH DEPT.

03630

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03624

Items 14 & 22a Film G308 3/12/62 1WK

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Emanuel Hunter</b>				4. DATE OF DEATH <b>March 2, 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1894</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Hydrographic U.S. Gov't.</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Eugene Hunter</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>256-10-9939</b>			
17. INFORMANT <b>Gussie Lenetta Hunter, Same as #2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/2/62</b> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. <b>JAMES I. BOYD, M.D.</b>					
EXAMINER'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/6/62</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State) <b>New Bern, North Carolina</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Frazier's Funeral Home, 389 R. I. Ave. NW., DC.</b>				24a. REC'D BY REGISTRAR <b>7 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. E. P. P.</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03625

03631

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY in 1b <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>20</u> <u>47X-3</u> d. STREET ADDRESS <u>1629 30th St. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Boone C</u> <b>HUTCHINSON</b> First Middle Last				<b>4. DATE OF DEATH</b> <u>March 21</u> , 19 <u>62</u> Month Day Year					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 23, 1874</u>		<b>9. AGE</b> (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Paper Hanger/Halter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Building</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>St. Mary's County, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S. of America</u>	
<b>13. FATHER'S NAME</b> <u>Josue Hutchinson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna C. Johnson</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes give war or dates of service) _____				<b>16. SOCIAL SECURITY NO.</b> <u>577-10-4442</u>		<b>17. INFORMANT</b> <u>Mrs. Louise Merritt</u> Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage &amp; Rb. Hemiplegia</u> (b) <u>Arteriosclerosis Generalized</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease about 20 yrs.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>40 yrs.</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>Aug. 14, 1954</u> to <u>March 21, 1962</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>March 21, 1962</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Walcutt W. Gibson</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <u>March 21, 1962</u>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Walcutt W. Gibson, M.D.</u>						<b>22d. ADDRESS</b> <u>4340 St. Barnabas Road, (21, D.C.)</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>3-24-62</u>				<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>		<b>23d. LOCATION</b> (City, town or county) <u>Suitland</u> (State) <u>Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home</u> ADDRESS <u>North 2, D.C.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>MAR 23 1962</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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*[Faint, illegible handwritten text at the bottom of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03632

03626

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 1 yr., 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) e. STATE D.C. b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 47X-3 d. STREET ADDRESS 5101 Just St., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Mabel B. Jackson		<b>4. DATE OF DEATH</b> Month Day Year 3 27 19 62	
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> Negro	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 1/13/08
<b>9. AGE</b> (In years last birthday) 54 yrs.		<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Laundry worker		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Unknown	<b>11. BIRTHPLACE</b> (County & State, or foreign country) Va.
<b>12. CITIZEN OF WHAT COUNTRY?</b> USA		<b>13. FATHER'S NAME</b> Robert L. Edmonds	
<b>14. MOTHER'S MAIDEN NAME</b> Marie Palmer		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) No	
<b>16. SOCIAL SECURITY NO.</b> 578-48-4764		<b>17. INFORMANT</b> Decedent	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hemorrhage, pulmonary, massive 002.1 DUE TO Pulmonary tuberculosis (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) coronary atherosclerosis		<b>INTERVAL BETWEEN ONSET AND DEATH</b> 1 day 1 year	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from 3/15/1966 to 3/27/1966, that (I) (we) last saw the deceased alive on 3/27/1966, and that death occurred at P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> Moe Weiss		<b>22b. DATE SIGNED</b> 3/27/62	
<b>22c. PHYSICIAN'S NAME</b> (Type) Moe Weiss, M.D.		<b>22d. ADDRESS</b> Glenn Dale Hospital Glenn Dale, Md.	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)	<b>23b. DATE THEREOF</b> 3-31-62	<b>23c. NAME OF CEMETERY OR CREMATORY</b> Petersburg VA	
<b>24. FURNERAL DIRECTOR'S SIGNATURE</b> Henry Washington		<b>25a. REC'D BY REGISTRAR</b> APR 3 '62	
<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Harris		<b>25c. ADDRESS</b> 4925 Reame Rd NE DC.	

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03627

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		b. COUNTY <b>Charles Anne Howard</b>	
c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambrills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>Box 451</b>	
3. NAME OF DECEASED (Type or print) <b>Virgie L. Jackson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV 14 1917</b>	
9. AGE (in years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>4</b> Hours <b>11</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13. FATHER'S NAME <b>John Cross</b>		14. MOTHER'S MAIDEN NAME <b>Minda Compton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Chester B. Jackson</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO (b) <b>Pelvic Cancer Probably</b> DUE TO (c) <b>Cancer of Cervix</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-10-1962</b> to <b>3-11-1962</b> that (I) (we) last saw the deceased alive on <b>3-11-1962</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin S. Pecson</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Pecson</b>		22d. ADDRESS <b>7028 Marlboro Pike, District Heights 28, Md.</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-14-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemt</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>		25a. REC'D BY REGISTRAR <b>MAR 14 '62</b>	
ADDRESS <b>Annapolis Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03634 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03628

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 10 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 05 Hall		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Hamilton Jefferson				4. DATE OF DEATH Month Day Year March 8th., 19 62			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1891	
9. AGE (In years last birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Marcel		14. MOTHER'S MAIDEN NAME Doris Sims		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Evelyn May Parker		17. INFORMANT Same as #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident 4 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio vascular renal disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/8/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Mar. 11, 62		22b. DATE THEREOF PLum Point		22c. NAME OF CEMETERY OR CREMATORY Calvert		22d. LOCATION (City, town, or country) (State) Md	
23. FUNERAL DIRECTOR Pinkney Sewell				24a. REC'D BY REGISTRAR DATE MAR 14 '62		24b. REGISTRAR'S SIGNATURE C. L. H. H. H.	

03052

03052

(M)

TO THE  
HONORABLE  
MEMBER OF PARLIAMENT  
FOR THE  
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## CERTIFICATE OF DEATH

Reg. Dist. No. 03629

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cedar Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>30 Cedar Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>904-64" Ave.</i>		d. STREET ADDRESS <i>904-64" Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Florence Johnson</i>		4. DATE OF DEATH Month <i>March</i> Day <i>2</i> Year <i>1962</i>	
5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>1884</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>P. Geo. Co. Welfare Dept.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i> 4-4-3X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO (c) <i>unknown</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lymphangitis</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1960</i> , 19, to <i>3-2-</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>3-1-</i> , 19 <i>62</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>John W. Robinson, M.D.</i> <i>1001 Eastern Ave. N.E.</i> PHYSICIAN'S NAME (Type) <i>John W. Robinson, M.D.</i> <i>Washington 27, D.C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washington &amp; Sons</i>		ADDRESS <i>4925 Denne Ave</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	
DATE <i>MAR 9 '62</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03636 CERTIFICATE OF DEATH 03630

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY in 1b 1 month and 23 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 910 O. St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hugh B. Johnson		4. DATE OF DEATH Month Day Year 3 7 19 62			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/7/13	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boot-black		10b. KIND OF BUSINESS OR INDUSTRY Mac's Valet Shop		11. BIRTHPLACE (County & State, or foreign country) Va.	
13. FATHER'S NAME John Willie Johnson		14. MOTHER'S MAIDEN NAME Rosa Lovings		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No -		16. SOCIAL SECURITY NO. 577-26-1260		17. INFORMANT Decedent	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized DUE TO (b) Carcinoma of the esophagus DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1/12/1962 to 3/7/1962, that (I) (we) last saw the deceased alive on 3/7/1962, and that death occurred at A.M., from the causes and on the date stated above.					
22a. SIGNATURE Moe Weiss		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/7/1962	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/9/62	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) Staunton, Virginia (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart		ADDRESS 304 St. N.E.		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
		DATE MAR 12 '62			

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W. H. H. H.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03637

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03631

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>49 Mount Rainier</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Julia M. Kelly</b>				4. DATE OF DEATH <b>March 2, 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1891</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Patrick Ducey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Derskin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Henry Kelly, same as # 2</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				DATE SIGNED <b>3/2/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>3/6/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR <b>Malley's Funeral Home Inc.</b>				24a. REC'D BY REGISTRAR <b>7 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kneass</b>	

03031

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of the certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03638

03632

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 22 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomfield		d. STREET ADDRESS 357 Belleville Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle P. Last KENNEDY		4. DATE OF DEATH Month Mar. 1st Day 1st Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/88
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Glasgow, Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kennedy		14. MOTHER'S M maiden NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Donald Kennedy, 3814-Y St., S.E., S.E.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Atherosclerosis + Congestive Heart Failure DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 20, 1962, to Mar 1, 1963, that (I) (we) last saw the deceased alive on Mar 1, 1962, and that death occurred at 1:25 M, from the causes and on the date stated above.			
22a. SIGNATURE J. H. Thibadeau		22b. DATE Mar. 1-1962	
22c. PHYSICIAN'S NAME (Type) Jos. H. Thibadeau		22d. ADDRESS 3112--Alabama Ave., S.E. Wash. 20 DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland MD	
24. FUNERAL DIRECTOR'S SIGNATURE Timmons Bros.		25a. REC'D BY REGISTRAR DATE MAR 2 '62	
ADDRESS 1661 Good Hope Rd. S.E. WASH. 20 DC		25b. REGISTRAR'S SIGNATURE Arthur L. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03639 CERTIFICATE OF DEATH 03633

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE CO.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY in 1b <b>74 Beltsville</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George Co.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville, Md.</b> d. STREET ADDRESS <b>5008 Cook Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William D. Kitchen</b>		4. DATE OF DEATH Month Day Year <b>march 11 1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-21-95</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fed. Empl.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>WW 1</b>	
16. SOCIAL SECURITY NO. <b>WW 1</b>		17. INFORMANT <b>Hosp. Records.</b> Address <b>As above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Carcinoma of Lungs.</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at <b>5:27</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles Gasch</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/13/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 13 '62</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

(M)

Bureau 3/13 1965  
Francis Gann's Son, Hyattsville, Md.

Colman, Mary

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Unknown

Unknown

Government

1910-1915

William D

1910-1915



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

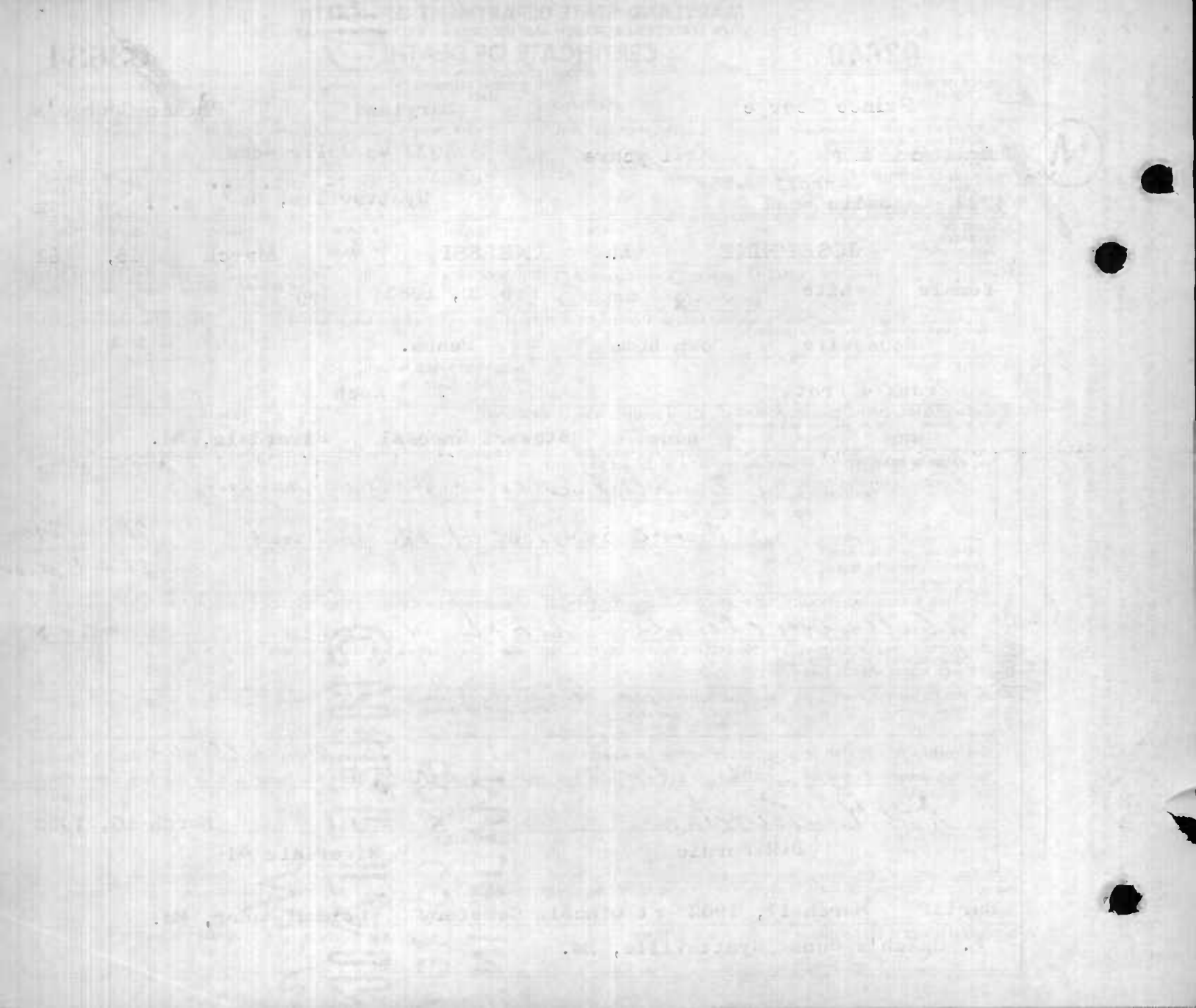
03640

CERTIFICATE OF DEATH

03634

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md</b>				c. LENGTH OF STAY IN 1b <b>11 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Manor</b> <b>4922 La Salle Road</b>				d. STREET ADDRESS <b>6902 - 21st. Ave.</b> <b>Hyattsville, Md / N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>M.</b> Last <b>KNEESSI</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1962</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 20, 1883</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Frank J Prott</b>				14. MOTHER'S MAIDEN NAME <b>? Koch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Stewart Kneessi</b> Address <b>Riverdale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma generalized</b> <b>170x</b> DUE TO <b>Cox</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the breast</b> DUE TO (c) <b>more than three years</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anterior sclerotic heart disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1962</b> to <b>March 15, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 15, 1962</b> , and that death occurred on <b>March 15, 1962</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>D. R. Purdie</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 15, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. R. Purdie</b>				22d. ADDRESS <b>Riverdale Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 17, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 20 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Carroll L. Kneessi</b>	

MEDICAL CERTIFICATION



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03641

03635

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>East Riverdale</b> c. LENGTH OF STAY in 1b <b>11 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5211 58th Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>39 East Riverdale</b> d. STREET ADDRESS <b>5211 58th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ZORA VIRGINIA KRITES</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 7, 1897</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>CHARLES SWISHER</b>				14. MOTHER'S MAIDEN NAME <b>EMMA ALBRIGHT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Arthur Cristian Krites Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> <b>Acute pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (b) <b>Congestive heart failure</b> (a), stating the underlying cause last. (c) <b>Cardiovascular renal disease</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				DATE SIGNED <b>3/24/62</b>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or country) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>			
24a. REC'D BY REGISTRAR <b>WAR 2 9 '62</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03642					03636				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)				
a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>					a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>19 SUITLAND</b>				
c. LENGTH OF STAY in 1b <b>1 DAY</b>					d. STREET ADDRESS <b>3308 TERRACE DRIVE SE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US AIR FORCE HOSPITAL ANDREWS</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED			4. DATE OF DEATH			5. IS RESIDENCE ON A FARM?			
(Type or print)			First Middle Last			Month Day Year			
<b>FRANK JOSEPH LANDRY JR</b>			<b>MARCH 21 19 62</b>						
5. SEX <b>MALE</b>			6. COLOR OR RACE <b>CAUCASIAN</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>20 MARCH 1962</b>			
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) <b>1</b>			IF UNDER 1 YEAR Months Days <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGES, MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			13. FATHER'S NAME <b>FRANK JOSEPH LANDRY SR</b>			14. MOTHER'S MAIDEN NAME <b>ETHEL FRANCES BAILEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT <b>FRANK J LANDRY (FATHER) SAME AS ITEM #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest of hemorrhage</b> <b>7605</b> DUE TO <b>intraventricular, right cerebrum, 3d and 4th ventricles</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Atelectasis, resorption, bilateral, cause undetermined</b> <b>Prematurity &amp; Immaturity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>28 hrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>28 hrs</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>20 MARCH 19 62</b>			20g. (County) <b>21 MARCH 19 62</b>			20h. (State) <b>1030P</b>			
21. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>20 MARCH 19 62</b> to <b>21 MARCH 19 62</b> that (I) <del>XX</del> last saw the deceased alive on <b>21 MARCH 19 62</b> and that death occurred at <b>1030P</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Arnold A. Abramo</b> <b>JOHN D. BLACKBURN, Capt USAF MC</b>			22b. DATE <b>21 MARCH 62</b>			22c. PHYSICIAN'S NAME (Type) <b>Arnold A. Abramo</b>			
22d. ADDRESS <b>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD</b>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-26-62</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Hall</b>			
23d. LOCATION (City, town or county) <b>Fl. Myer</b>			23e. (State) <b>Va.</b>			23f. ADDRESS			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>			24a. ADDRESS <b>517-10th St SE</b>			25a. REC'D BY REGISTRAR <b>DATE MAR 27 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>			25c. ADDRESS			25d. ADDRESS			

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US AIR FORCE HOSPITAL WARDENS  
WARDEN  
JOSEPH  
LARRY JR  
MARCH 21  
1962  
PRINCE GEORGES, WARDEN, UNITED STATES  
WORKING DAILY  
PEACE & LABOR (VETERAN) 2000 AS ETC

JOHN D. STARKMAN, CAPT USAF MC, USAF HOSPITAL, WARDEN AIR FORCE BASE  
21 MARCH 62  
21 MARCH 62  
21 MARCH 62



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Coshocton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Walhonding</b> d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Emma Jane Langdon</b>						<b>4. DATE OF DEATH</b> <b>March 5 19 62</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 17, 1895</b>		<b>9. AGE (In years last birthday)</b> <b>66</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>West Virginia</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		
<b>13. FATHER'S NAME</b> <b>Robert Bennett</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Tanner</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>no</b>		<b>17. INFORMANT</b> <b>John Frederick Langdon, same as # 2</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> (b) <b>C ardiovascular renal dñease</b> (c) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>James I. Boyd</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>3/5/62</b> <b>DATE SIGNED</b>					
<b>EXAMINER'S NAME</b> (Type) <b>James I. Boyd</b>						<b>Address</b> (Street, city, town, or county)					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>March 9-62</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>New Castle</b>		<b>22d. LOCATION</b> (City, town, or country) <b>New Castle, Ohio</b>		<b>(State)</b>			
<b>23. FUNERAL DIRECTOR</b> <b>Sumner Bros</b>				<b>ADDRESS</b> <b>1661-9d Hype Rd</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAR 8 '62</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

Wash DC

03032



Handwritten text at the bottom of the page, including the name "John C. Smith" and other illegible markings.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03638

03644

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FOR STATE HEALTH DEPT. M  
99  
2  
2  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1 should be executed the day after death, and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN TB <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert Buffington Lantz</b>		4. DATE OF DEATH <b>March 27th., 1962</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 4th. 1896</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>			
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Isaac Newton Lantz</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN - Buffington</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WW 1</b>				16. SOCIAL SECURITY NO. <b>184-10-0319</b>			
17. INFORMANT <b>Norma Lowery Lantz</b>				18. CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> DUE TO (b) <b>Myocardial infarction &amp; rupture</b> DUE TO (c) <b>Coronary Atherosclerosis &amp; Heart Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>3/27/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-30-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenn Run Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Atglen, Penna</b>	
23. FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 30 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03645  
CERTIFICATE OF DEATH  
03639

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>Jeremia</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>76</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>64 University Park</u> d. STREET ADDRESS <u>4220 Sheridan St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>A</u> Last <u>Lesner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1962</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-07</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraving</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Geological Survey Interior Dept.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Nicholas Lesner</u>				14. MOTHER'S MAIDEN NAME <u>Roth</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>217 44 0458</u>		17. INFORMANT <u>Rosa Lesner University Park, Md</u> Address <u>  </u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>42000</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio sclerotic Heart Dis.</u> (c) <u>  </u> DUE TO (e), stating the underlying cause last. (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>8 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>  </u>		(County) <u>  </u>		(State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1962</u> to <u>March 2, 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar 2, 1962</u> and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>L W Mullen</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3-2-62</u>							
22c. PHYSICIAN'S NAME (Type) <u>L W Mullen M.D.</u>				22d. ADDRESS <u>Riverdale Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) <u>Suitland Md.</u>				(State) <u>  </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 7 1962</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>					





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03640

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale) c. LENGTH OF STAY IN 1b 1 mo., 22 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 108 Atlantic St., S.E. Apt 303 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JULIAN CLARK LEVELL			4. DATE OF DEATH March 9 19 62				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1900		9. AGE (In years last birthday) 61		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab-driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi		11. BIRTHPLACE (County & State, or foreign country) Laray, Virginia			
13. FATHER'S NAME Bureguard Levell			14. MOTHER'S MAIDEN NAME Martha Skelton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Person			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, recurrent 420 } DUE TO Conditions, if any, which } (b) Coronary artery heart disease gave rise to immediate cause } (a), stating the underlying } DUE TO cause last. } (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy with urethral obstruction.					INTERVAL BETWEEN ONSET AND DEATH 1 day unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/15/62 to 3/9/62, that (I) (we) last saw the deceased alive on 3/9/62, and that death occurred at 5:44 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss		22b. DATE March 9, 1962		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.			
22d. ADDRESS Glenn Dale Hospital. Glenn Dale, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/62	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Bladensburg, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Sam Maxwell Butler		ADDRESS 1661 Glad Hope Rd. Wash DC		25a. REC'D BY REGISTRAR DATE MAR 13 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01810

TO THE HONORABLE SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above subject.  
In reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
Your obedient servant,  
J. M. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03647

03642

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>			
c. LENGTH OF STAY in 1b <u>55 yrs</u>				d. STREET ADDRESS <u>910 Myrtle Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>910 Myrtle Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Leonard Lowman</u>				4. DATE OF DEATH <u>March 3, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31 1870</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Horse Farm</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Margie Lowman</u> Address <u>Bowie, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Vascular - Renal Dis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u>							
(c) <u>Essential Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 1956 to <u>Mar</u> 1962 that (I) (we) last saw the deceased alive on <u>March 2</u> 1962 and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry A. Wise Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/3/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 6, 1962</u>		23c. NAME OF CEMETERY OR <del>CHURCH</del> <u>Nicholas Memorial</u>	
23d. LOCATION (City, town or county) <u>Odenton</u>				(State) <u>Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>WAB</u> DATE <u>7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

03812

EXHIBIT OF CLAY

03812

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Exhibit of Clay

Exhibit of Clay

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.  
After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03648  
CERTIFICATE OF DEATH  
03643

1. PLACE OF DEATH a. COUNTY <b>Parince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> c. LENGTH OF STAY IN 1b <b>1mo. 12d</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suitland Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Parince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 Oxen Hill</b> d. STREET ADDRESS <b>4408 Brockton Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <b>Syons, James</b>		4. DATE OF DEATH Month <b>March</b> Day <b>12,</b> Year <b>1962</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/4/79</b>		9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>				11. BIRTHPLACE (County & State, or foreign country) <b>u.s.a.</b>				12. CITIZEN OF WHAT COUNTRY? <b>u.s.a.</b>											
13. FATHER'S NAME <b>Syons, James</b>				14. MOTHER'S MAIDEN NAME <b>Annie Keane</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-01-3263</b>				17. INFORMANT <b>Rt 2- Box 110-9 Bernard Syons-Vienno, Virginia</b>							
18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerotic Heart Disease</b> (c) <b>yes</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATIVE TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Snapping of Coccyx of Colon Rectum</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>											
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20d. (City or town) <b>3/12/62</b>				20e. (County) <b>Washington, D.C.</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>3/9/62</b> to <b>3/12/62</b> , that (I) (we) last saw the deceased alive on <b>3/9/62</b> , and that death occurred at <b>3/12/62</b> from the causes and on the date stated above.				22a. SIGNATURE <b>J. G. Donovan</b>				22b. DATE <b>3/14/62</b>				22c. PHYSICIAN'S NAME (Type) <b>J. G. Donovan</b>				22d. ADDRESS <b>2811 P. Ave NE</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/15/62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cem</b>				23d. LOCATION (City, town or county) <b>Washington, D.C.</b>				23e. REC'D BY REGISTRAR <b>14 '62</b>				23f. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>				24b. ADDRESS <b>300-4th St. N.E. Wash</b>				24c. DATE <b>3/15/62</b>				24d. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				24e. ADDRESS <b>300-4th St. N.E. Wash</b>							

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. 155ME  
5M 9/60

FOR STATE  
HEALTH DEPT.

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2

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03649					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					03644				
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>04 Lanham</b> d. STREET ADDRESS <b>1 Box 266 Defense Highway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Norman Magnus MacLeod</b>			First Middle Last		4. DATE OF DEATH <b>March 31</b> Month Day Year			19 <b>62</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-21-1900</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired News Reporter</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>William C. MacLeod</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Jane McKelvie</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <b>221-26-7944</b>		17. INFORMANT Address <b>Margaret S. MacLeod same as #2</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Second and Third Degree Burns (43% body area)</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Arteriosclerotic Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Clothing ignited when deceased struck a match.</b>									
20c. TIME OF INJURY Month, Day, Year <b>5</b> Hour a.m. <b>March 25</b> 19 <b>62</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Lanham, Prince Georges, Md.</b>		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>James I. Boyd, M.D.</b>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3-31-62</b>							
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>					22b. DATE THEREOF <b>4/4/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fernwood Cemetery</b>		22d. LOCATION (City, town, or country) <b>Philadelphia, Pa.</b>					
23. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b>					23b. ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		24e. REC'D BY REGISTRAR <b>APR 5 '62</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. Hines</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03650				CERTIFICATE OF DEATH				03645			
Item 13 From birth certificate											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b. <b>15 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 Camp Springs</b> d. STREET ADDRESS <b>6733 Prince Georges</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby "A" Boy MacMillan</b>				4. DATE OF DEATH Month Day Year <b>March 24 19 62</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>24 March 1962</b>		9. AGE (In years last birthday) yrs. Months Days <b>15</b>		IF UNDER 1 YEAR Months Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>				11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frederick Shaw MacMillan</b>						14. MOTHER'S MAIDEN NAME <b>Edna Pearl Lawrence</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>Mother</b>				17. INFORMANT <b>Same as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>prematurity</b> Conditions, if any, which gave rise to immediate cause (b) <b>at ectasia</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-24</b> , <b>1962</b> , to <b>3-24</b> , <b>1962</b> that (I) (we) last saw the deceased alive on <b>3-24</b> , <b>1962</b> , and that death occurred at <b>6:14 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas A. Christensen</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen</b>						22b. DATE SIGNED <b>9/25/62</b> 22d. ADDRESS <b>6905 Baltimore Ave., College Park,</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>3-31-62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b>				25a. REC'D BY REGISTRAR DATE <b>APR 3 '62</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

2-045960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03651						Item 13 info. from birth certificate			03646		
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
a. COUNTY			Prince Georges			a. STATE			b. COUNTY		
			MARYLAND			Maryland			Prince Georges		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Cheverly			27 hrs			14 Camp Springs			1 6733 Prince George Dr.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)									a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Prince Georges General Hospital											
3. NAME OF DECEASED						4. DATE OF DEATH			5. AGE (In years last birthday)		
First			Middle			Last			Month		
Baby Boy "B "			MacMillan						25 19 62		
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH		
Male			White			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			24 March 1962		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
						Maryland			U.S. A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Frederick Shaw MacMillan						Edna Pearl Lawrence					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.			17. INFORMANT		
									Mother		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO premature Conditions, if any, which gave rise to immediate cause (b) atelectasis (a), stating the underlying cause last. } DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-24 1962, to 3-25 1962, that (I) (we) last saw the deceased alive on 3-25 1962, and that death occurred at 6:40AM from the causes and on the date stated above.											
22a. SIGNATURE Dr. Thomas A. Christensen						22b. DATE SIGNED 3/25/62			22c. PHYSICIAN'S NAME (Type)		
Dr. Thomas A. Christensen						M.D.			22d. ADDRESS 6905 Baltimore Ave., College Park, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY		
Cremation						3-31-62			Prince Geo. Gen. Hospital		
24. FUNERAL DIRECTOR'S SIGNATURE						24b. ADDRESS			25a. REC'D BY REGISTRAR		
Harry W. Penn, Jr., Administrator									DATE APR 3 '62		
									25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

2-0459/59

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03652					03647				
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>-</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>					c. LENGTH OF STAY IN 1b <b>adm. June 18, 1960</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>LAUREL SANITARIUM</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 3V01-4				
d. STREET ADDRESS <b>6216 HIGHTOP Ave.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JDA</b> Middle <b>S.</b> Last <b>MAKODZUB</b>					4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1962</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-5-1872</b>		9. AGE (In years last birthday) <b>90</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>S. NOWAKOWSKI</b>					14. MOTHER'S MAIDEN NAME <b>-</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <b>unknown</b>				
17. INFORMANT <b>Hosp. Records</b> Address <b>LAUREL SANITARIUM</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, lobar (490)</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>490x</b> (e), stating the underlying cause last. <b>-</b> DUE TO (c) <b>-</b>									INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cerebral arteriosclerosis &amp; senility</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m. <b>-</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>6-18-1960</b> to <b>3-18-1962</b> that (I) (we) last saw the deceased alive on <b>3-18-1962</b> , and that death occurred at <b>9:20 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Enika P. Kraemer</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3-18-62</b>		
22c. PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>					22d. ADDRESS <b>LAUREL SANITARIUM</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b. DATE THEREOF <b>3/21/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fernchiff Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Heatedale N.Y.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert R. Raulston</b>					25a. REC'D BY REGISTRAR <b>MAR 20 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03648

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
c. LENGTH OF STAY IN 1b 1 month and 6 days				d. STREET ADDRESS 1277 Brentwood Rd., NE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gladys E. McConville				4. DATE OF DEATH Month 3 Day 8 Year 19 62			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/5/08	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator				10b. KIND OF BUSINESS OR INDUSTRY Peoples Drug Store Va.			
11. BIRTHPLACE (County & State, or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Fenton M. Fitzhugh				14. MOTHER'S MAIDEN NAME Nettie Travers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 577-05-5063			
17. INFORMANT Decedent				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left intraventricular hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis; left thoracoplasty, 1941; healed myocardial infarction; arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/2/1962 to 3/8/1962, that (I) (we) last saw the deceased alive on 3/8/1962, and that death occurred at A.M., from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 3/8/62			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-12-1962		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT FORT MYER VA		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				25a. REC'D BY REGISTRAR DATE MAR 14 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03649

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ardmore X			d. STREET ADDRESS Box 385		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Doris Middle May Last McDonnell					4. DATE OF DEATH March 12th 1962					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25, 1962		9. AGE (in years last birthday) yrs. 15		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Francis McDonnell					14. MOTHER'S MAIDEN NAME Katherine Elizabeth Osborn					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none		17. INFORMANT Address Katherine E. McDonnell, same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE James I. Boyd					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial					22b. DATE THEREOF Mar. 15, 1962		22c. NAME OF CEMETERY Washington National		22d. LOCATION (City, town, or country) Suitland, Maryland	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,					ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE MAR 15 '62		24b. REGISTRAR'S SIGNATURE	

2-028360

M



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03655

03650

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files of the State Department of Health. Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Brentwood			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 4318 41st Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B&O R.R. Tracks at intersection of Volta Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DONALD LYNN MC GARGLE				4. DATE OF DEATH March 28 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1956	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry William Mc Gargle				14. MOTHER'S MAIDEN NAME Elver Virginia Ennis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Address Elver V. Mc Gargle Same as #2							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (b) Trauma - multiple and severe (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 3:35 p.m. 3/28 1962				20d. PLACE WHERE INJURY OCCURRED (City or town) (County) (State) Brentwood P. G. Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-31-1962			
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.				22d. LOCATION (City, town, or country) (State) Bladensburg, Maryland			
23. FUNERAL DIRECTOR W.W. Chambers Co. Pimlico, Md				24a. REC'D BY REGISTRAR APR 2 '62			
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

21920



Researcher's name: \_\_\_\_\_

582



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03656 CERTIFICATE OF DEATH 03651

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Montgomery</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> h. STREET ADDRESS <b>8203 Houston Court</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William McGinn</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1902</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>12</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Cornelius McGinn</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Rodgers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Lavenia McGinn Same as #2 (Wife)</b>	
17. INFORMANT <b>Lavenia McGinn Same as #2 (Wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Metastasis to Liver</b> DUE TO (c) <b>Pulmonary Edema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5 a.m.</b> 1965 to <b>2/22</b> 1962 that (I) (we) last saw the deceased alive on <b>2/22</b> 1962 and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John Kehoe</b> M.D.		22b. DATE SIGNED <b>A.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John Kehoe</b>		22d. ADDRESS <b>6300 Riverdale Rd., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/26/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. asch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

(M)

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RECEIVED

EXHIBIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03657  
CERTIFICATE OF DEATH  
03652

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>7308 C Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bernard E. McIntire</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-13-15</b>
9. AGE (In years last birthday) <b>47 yrs.</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David McIntire</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Richardson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Annabelle McIntire-wife</b>		Address <b>7308-C. Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Congestive Heart Failure</b> DUE TO <b>Pulmonary Congestion</b> (b) DUE TO <b>Arteriosclerotic Heart Diseases</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 days</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>420.0</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/5/62</b> to <b>3-5</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>3/5/62</b> , and that death occurred at <b>3:25 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William Brainin</b> M.D.		22b. DATE SIGNED <b>3/5/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		22d. ADDRESS <b>6124 Central Ave, Capital Hill Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-8-62</b>	23b. DATE THEREOF <b>3-8-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 8831 P.C.</b>		25a. REC'D BY REGISTRAR DATE <b>7 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			



038228

038228

CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE COMPLETED BY THE PHYSICIAN WHO HAS ATTENDED THE DECEASED OR BY THE PHYSICIAN WHO HAS BEEN CONSULTED IN CONNECTION WITH THE DEATH.

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PHYSICIAN'S SIGNATURE: [illegible]

PHYSICIAN'S NAME: [illegible]

PHYSICIAN'S ADDRESS: [illegible]

XX

RECEIVED FROM 038228



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03658

## CERTIFICATE OF DEATH

03653

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u> c. LENGTH OF STAY IN 1b <u>26 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pain Branch Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 1523-2 d. STREET ADDRESS <u>8401 Manchester Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Elizabeth Katherine Michelson</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>March 20 1962</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 5, 1926</u>
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Insurance broker - Chicago, Ill.</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U. S. A.</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Thomas C. Adams</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine Cubbage</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>Records of Pain Branch Nurs Home</u>		<b>17. INFORMANT</b> <u>Records of Pain Branch Nurs Home</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-22 Congestive heart failure</u> DUE TO (b) <u>Renal and atherosclerotic cardio-vascular disease.</u> DUE TO (c) <u>vascular disease.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>—</u>	<b>20f. (City or town) (County) (State)</b> <u>—</u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 25, 1962</u> <b>to</b> <u>March 20, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>20 Mar. 1962</u> <b>and that death occurred at</b> <u>11 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Ernest Effamon</u> M.D.		<b>22b. DATE SIGNED</b> <u>Mar 23 1962</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Ernest Effamon</u>		<b>22d. ADDRESS</b> <u>9301 Colville Rd, Silver Spring, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>	<b>23b. DATE THEREOF</b> <u>3/23/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lee Crematory</u>	<b>23d. LOCATION (City, town or county) (State)</b> <u>300 H St NE Wash D.C.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Lee &amp; Sons</u>		<b>25a. REC'D BY REGISTRAR</b> <u>300 H St NE</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. House</u>

03823

03823



These are the only  
copies of the  
originals in the  
country  
and are the only  
ones that are  
available for  
reference.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03654

03659

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES.</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL Hyattsville</u> c. LENGTH OF STAY IN 1b <u>5 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PAINT BRANCH Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>WASH DC</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>330 Rhode Island Ave #105</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>RICHARD IGNATIUS MILLER</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>MARCH 12 1962</u> Month Day Year									
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan 10, 1898</u> last birthday		<b>9. AGE</b> (In years) <u>64</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PRESS MAN</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>PRINTING Shop.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Upper Marlboro Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Henry S. Miller</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Francis Eleanor Owings</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>578-05-6976</u>				<b>17. INFORMANT</b> Address <u>Maud F Goddard 4315 40th N Brentwood</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA</u> (b) <u>CARCINOMATOSIS, GENERALIZED</u> (c) <u>PRIMARY CA OF RECTOSIGMOID</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>FEB 1, 1962</u> <b>to</b> <u>MAR. 7, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>MARCH 7, 1962</u> <b>and that death occurred at</b> <u>1:30 P.M.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Luther W. Gray</u> <b>M.D.</b>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/12/62</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>LUTHER W. GRAY, MD.</u>						<b>22d. ADDRESS</b> <u>1302 18th St., N.W., WASH 6, D.C.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>3/14/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln</u>				<b>23d. LOCATION (City, town or county)</b> (State) <u>Colman Manor, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kalleys Funeral Home</u> <b>ADDRESS</b> <u>Mt. Rainier Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>MAR 15 '62</u> <b>DATE</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Farris</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and return it to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03660

03655

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park X</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>First Branch Nursing Home</u>				d. STREET ADDRESS <u>6801 Woodland Hds.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>James William Minsweiser</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>25</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 15, 1924</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Contract builder</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Minsweiser</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Moser</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>206-03-7015</u>		<b>17. INFORMANT</b> <u>Nursing home records</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis -</u> <u>33 4 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause last. } DUE TO <u>Anemia</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>old -</u> <u>old.</u> <u>1 wk.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept. 240 P.</u> <u>1961</u> <u>3/25/62</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>3/24</u> <u>1962</u> , and that death occurred at <u>3/25</u> <u>1962</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Ernest A. Sarao</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/25/62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ERNEST A. SARAO.</u>				<b>22d. ADDRESS</b> <u>7006 New Hampshire Ave. Takoma Park Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>March 28, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Date of Heaven Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Montgomery County, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur H. Hutter</u>				<b>25. REC'D BY REGISTRAR</b> <u>Arthur H. Hutter</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Arthur H. Hutter</u>	

03005

03005



202-03-202

High Time  
Dinner

10:15

Arrival at 10:15

Guest A 10:15

10:15

Guest B 10:15

Guest C 10:15  
Guest D 10:15  
Guest E 10:15  
Guest F 10:15  
Guest G 10:15  
Guest H 10:15  
Guest I 10:15  
Guest J 10:15  
Guest K 10:15  
Guest L 10:15  
Guest M 10:15  
Guest N 10:15  
Guest O 10:15  
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Guest Q 10:15  
Guest R 10:15  
Guest S 10:15  
Guest T 10:15  
Guest U 10:15  
Guest V 10:15  
Guest W 10:15  
Guest X 10:15  
Guest Y 10:15  
Guest Z 10:15



12  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the above information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: The Chief Medical Examiner's Office will issue a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03656

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>1 hour</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>36 Lanham</b> d. STREET ADDRESS <b>9014 Magnolia Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>RICHARD EUGENE MITCHELL</b>			4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 62</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>November 11, 46</b>		
9. AGE (In years last birthday) <b>15</b> yrs.			10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		
11. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>EUGENE TULLIS MITCHELL</b>			14. MOTHER'S MAIDEN NAME <b>ROSEMARY ARDIS YOUNG</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT <b>ROSEMARY ARDIS Mitchell</b>			Address <b>Same as #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>8 12X Hemorrhage and shock</b> DUE TO (b) <b>Fracture of the skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by an automobile</b>		
20c. TIME OF INJURY Month, Day, Year <b>1:30 xx 3/24/62</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 704</b>			20f. (City or town) (County) (State) <b>Glen Arden P. G. Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>3/24/62</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery Colmar Manor, Pr. Geo. Co., Md.</b>	
22d. LOCATION (City, town, or country) (State) <b>3/24/62</b>		23. FUNERAL DIRECTOR ADDRESS <b>W.W. Chambers Company, Riverdale, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



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03662

CERTIFICATE OF DEATH

Reg. Dist. No. 03657

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morningside</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland,</b>	
c. LENGTH OF STAY IN 1b <b>@ 7 yrs</b>		d. STREET ADDRESS <b>3101 Parkway Ter. Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5820 Skyline Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Elizabeth Moore</b>		4. DATE OF DEATH <b>3 - 17 - 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1902</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Galligan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Conroy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ivan R. Moore</b>		Address <b>#2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the cervix &amp; undischarged metastases</b> DUE TO (b) <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>171X</b> DUE TO (c) <b>171X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Nov. 1961</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Breast carcinoma</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1956</b> , to <b>3/17, 1962</b> , that I last saw the deceased alive on <b>3/11, 1962</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward J. Pacious</b> M.D.		ADDRESS (Street, city or town, state) <b>1746 K ST. N.W.</b> DATE SIGNED <b>3/17/62</b>	
PHYSICIAN'S NAME (Type) <b>Edward J. Pacious</b>		<b>1746 K St., NW Washington, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/21/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jas. T. Ryan, Inc. by G. T. Swift</b>		ADDRESS <b>SE. Wash. D.C. 317 Pa. Ave</b>	DATE <b>MAR 20 '62</b>
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03663  
03658  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>1441 Newton Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jessie Mae Moran</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1891</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Chantilly, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Milton Moran</b>		14. MOTHER'S MAIDEN NAME <b>Flora Virginia Moran</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Milton A. Moran</b>		Address <b>Washington, D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Massive Cerebral Hemorrhage (Lt. Temporo-Occipital lobe)</b> DUE TO (b) <b>2. Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>3. Hypertensive arteriosclerosis heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260 X</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 25th, 1962</b> to <b>March 27th, 1962</b> , that (I) <b>XX</b> last saw the deceased alive on <b>March 27th, 1962</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>T. H. Bergemann</b>		22b. DATE SIGNED <b>3-27-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Teil Bergemann</b>		22d. ADDRESS <b>53-A Crescent Rd. #108, Greenbelt, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>	23b. DATE THEREOF <b>3-30-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>McCulloch Cemetery,</b>	23d. LOCATION (City, town or county) (State) <b>Sterling, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Berkley Green</b>		25a. REC'D BY REGISTRAR <b>Herndon, Virginia</b>	
25b. REGISTRAR'S SIGNATURE <b>3-29-62</b>		25c. REGISTRAR'S SIGNATURE <b>3-29-62</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03664

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03659

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>40</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>5504 Tilden Road</b>	
3. NAME OF DECEASED (Type or print) <b>Bertha</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 62</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 1, 1879</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Thomas Smyth Odell</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Banta</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>James Harry Morrison, same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Cerebrovascular accident</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. <b>JAMES I. BOYD, M.D.</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/26/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/30/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Maple Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Plainfield Indiana</b>	
23. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>		24a. REC'D BY REGISTRAR <b>3/29/62</b>	
24b. REGISTRAR'S SIGNATURE <b>Riverdale, Md.</b>		24c. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>	

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W. A. Chambers Co. - Riverdale, Ill.

Chicago, Ill. - 1914

June 1, 1914

Mr. J. M. [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03665  
03660

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 3 Hrs. 5 Min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5123 Crittenden Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maude Middle pearl Last Mullikin		4. DATE OF DEATH Month March Day 12 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1882
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME Edward Whittington	
14. MOTHER'S MAIDEN NAME Sarah Ford		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Curtis E. Mullikin Same as #2 (son) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct DUE TO (b) Pulmonary Edema DUE TO (c) Arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/12/62 to 3/12/62, 19 62, and that (I) (we) last saw the deceased alive on 3/12/62, 19 62, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Barry Rosenberg M.D.		22b. DATE SIGNED 3/12/62	
22c. PHYSICIAN'S NAME (Type) Dr. Barry Rosenberg		22d. ADDRESS 1210 Chillum Manor Rd., West Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/62	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE MAR 15 '62	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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0360

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03665

03661

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>70 College Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5100 Bernyn Rd</i>		d. STREET ADDRESS <i>15100 Bernyn Road</i>	
3. NAME OF DECEASED (Type or print) <i>HELEN</i> First <i>LOUISE</i> Middle <i>NEITZEY</i> Last		4. DATE OF DEATH <i>Mar 10 1962</i> Month <i>Mar</i> Day <i>10</i> Year <i>1962</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC 18, 1936</i> last birthday
9. AGE (In years last birthday) <i>25</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Analyst</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Commerce Dept</i>	11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Walter N. Neitzey</i>	
14. MOTHER'S MAIDEN NAME <i>Dorothy Smith</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Mrs Dorothy Neitzey</i> Address <i>same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Dyslipquant Lymphoma, Hodgkin's type, cervical nodes, &amp; metastasis to chest &amp; lungs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>200</i> (c) <i>metastasis to chest &amp; lungs</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 1960</i> to <i>Mar 1962</i> , that (I) (we) last saw the deceased alive on <i>MAR 9 1962</i> , and that death occurred at <i>8 A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>W. C. Etienne</i>		22b. DATE SIGNED <i>3/19/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. C. ETIENNE</i>		22d. ADDRESS <i>4713 Bernyn Rd College Park</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>3-13-62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washington Mem. Park</i>	23d. LOCATION (City, town, or county) (State) <i>W. Hyattsville, Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers, Newdale</i>		25a. REC'D BY REGISTRAR <i>MAR 14 '62</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>

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1880

CERTIFICATE OF DEATH

1880

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I hereby certify that on the 13th day of March 1880 at the City of New York in the County of New York died of the effects of a severe cold and influenza the following named person

John Doe of the County of New York in the City of New York aged 45 years of legal age and of sound mind and memory and of the County of New York in the State of New York

Witness my hand and the seal of the City of New York this 14th day of March 1880



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03667

Item 9 Film G311 4/12/62 mh

CERTIFICATE OF DEATH

03662

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 7 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 70 College Park d. STREET ADDRESS 5500 Richmond Avenue, Lakeland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Garfield Nickens		4. DATE OF DEATH Month Day Year March 30 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-1899
9. AGE (In years last birthday) 62 6/3		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Nickens		14. MOTHER'S MAIDEN NAME Lula Webb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT David Nickens Address 4001 Hampden St., Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 28 6 45 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Malnutrition, dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-29 1962, to 3-30 1962, that (I) (we) last saw the deceased alive on 3-30 1962, and that death occurred at 6:45, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Benjamin S. Pecson M.D.		ATTENDING A.M. MED. STAFF PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input checked="" type="checkbox"/> 22b. ADDRESS 7028 Marlboro Pike, District Hgts., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National.		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE APR 6 1962 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03668

03663

1. PLACE OF DEATH a. COUNTY <b>Prince George County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>			
c. LENGTH OF STAY IN 1b <b>19 years</b>				d. STREET ADDRESS <b>1800 Brooklyn Bridge Rd., Laurel</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1800 Brooklyn Bridge Rd. Laurel, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM ALBERT NORTHROP</b>				4. DATE OF DEATH <b>March 29 19 62</b>			
S. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/29/06</b>	
9. AGE (In years lost birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR <b>Months Days Hours Min.</b>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Ashland, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Northrup</b>				14. MOTHER'S MAIDEN NAME <b>Anne Cope</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-01-8792</b>		17. INFORMANT <b>Wife- Mrs. Ann Viola Northrup</b> Address <b>1800 Brooklyn Bridge Rd Laurel, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion 2d attack</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension - myocardial infarction</b> DUE TO <b>3 yrs</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b> (b) <b>—</b> (c) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> 19 <b>—</b> p. m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec-15 19 59</b> to <b>3/29 1962</b> that (I) (we) last saw the deceased alive on <b>3/27 1962</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>N.B. Stewart</b>				22b. DATE SIGNED <b>APR 3 '62</b>			
22c. PHYSICIAN'S NAME (Type) <b>N.B. STEWARD</b>				22d. ADDRESS <b>314 Compman Laurel Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 31, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGES CO., MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Thomas</b>				25a. REC'D BY REGISTRAR <b>APR 3 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

MEDICAL CERTIFICATION

(M)

CERTIFICATE OF DEATH

1952

1952

Blank area for text, containing faint horizontal lines and some illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03669

03664

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural (Hyattsville.)</u> c. LENGTH OF STAY IN 1b <u>3yrs 3mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PAINT BRANCH Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>15606 31<sup>st</sup> Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wilhelmina</u> First <u>NORUELL</u> Middle <u>NORUELL</u> Last		<b>4. DATE OF DEATH</b> <u>MAR</u> Month <u>15</u> Day <u>1962</u> Year		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>AUG 17, 1873</u>		<b>9. AGE</b> (In years last birthday) <u>88</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Lenoxing Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>					
<b>13. FATHER'S NAME</b> <u>Henry Milford</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Schaidt</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>NONE</u> <b>17. INFORMANT</b> <u>James Noruell</u> Address <u>4305 Wheeler Rd S.E.</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute massive gastric hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized.</u> (c) <u>Arteriosclerosis CVD.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>														<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>20 min.</u> <u>15 yrs.</u> <u>15 yrs.</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from <u>3-2</u>, 19<u>55</u>, to <u>3-15</u>, 19<u>62</u>; that (I) (we) last saw the deceased alive on <u>3-8</u>, 19<u>62</u>, and that death occurred at <u>7:30 AM</u>, from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>R.D. Baker M.D.</u> M.D. <b>22b. DATE SIGNED</b> <u>3-15-62</u>														<b>22c. PHYSICIAN'S NAME</b> (Type) <u>R.D. Baker, M.D.</u>		<b>22d. ADDRESS</b> <u>2513 Buckleup Rd. Rte 1, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>3/17/62</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Shenwood Cent.</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Wash. D. C.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Lees</u> ADDRESS <u>Wash. D. C.</u>										<b>25a. REC'D BY REGISTRAR</b> <u>  </u> DATE <u>MAR 19 '62</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION



1992

51

7-2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4  
may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

Reg. Dist. No. 03665

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 District Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7111 Dist. Hgts. Parkway</u>		d. STREET ADDRESS <u>7111 Dist. Hgts. Pkway</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Beatrice</u> First Middle Last		4. DATE OF DEATH <u>March 5</u> Month Day Year <u>19 62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1898</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward White</u>		14. MOTHER'S MAIDEN NAME <u>Jean Courtney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1962</u> , to <u>March 5, 1962</u> , that I last saw the deceased alive on <u>March 5, 1962</u> and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>BENJAMIN S. PERSON</u> M.D.		ADDRESS (Street, city or town, state) <u>7078 Morebno Pike WASH. 28. D C</u>	
DATE SIGNED <u>3-5-62</u>			
22a. REC'D BY REGISTRAR <u>MAR 8 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	
22b. DATE THEREOF <u>3/8/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jas. T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave., SEDC3</u>			

Let's Face It, Inc. - 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03671

03666

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 Hrs. 8 Min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 2768</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>#1 Baby Boy Perrie</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>March 3 19 62</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 3, 1962</b>	
<b>9. AGE</b> (In years last birthday) <b>3 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days <b>3 8</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Md</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Thelma Aretta Norfolk Perrie</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>Mother</b>	
<b>17. INFORMANT</b> <b>Same as above</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity - 32-34 weeks gestation</b> DUE TO (b) <b>776</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>10 minutes</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 3-3, 1962, to 3-3, 1962, that (I) (we) last saw the deceased alive on 3-3, 1962, and that death occurred at 11:50 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>R. Robert Sasscer</b> M.D.		<b>22b. DATE</b> <b>P.M.</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Robert Sasscer</b>		<b>22d. ADDRESS</b> <b>R.F.D. Box 2150, Upper Marlboro, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>3-17-62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prince Geo.Gen.Hospital</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cheverly, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Harry W. Renn, Jr. Adm.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 21 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Hanna</b>			

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DEPARTMENT OF HEALTH

1911

THE SECRETARY OF THE BOARD OF HEALTH

TO THE BOARD OF HEALTH

RE: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TOTAL FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03672

CERTIFICATE OF DEATH

03667

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 2768</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>3 Hrs. 9 Mins</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>#2 Baby Boy</b>				<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>3</b> Year <b>19 62</b>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>March 3, 1962</b>			
9. AGE (In years last birthday) <b>3</b> yrs.				10. IF UNDER 1 YEAR Months <b>3</b> Days <b>9</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <b>Ind</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Thelma Aretta Norfolk Perrie</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mother</b>				Address <b>Same as above</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause on line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>776X</b> IMMEDIATE CAUSE (e) <b>Immaturity - 22-24 wks gestation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-3</b> , 19 <b>62</b> to <b>3-3</b> , <b>62</b> ; that (I) (we) last saw the deceased alive on <b>3-3</b> , 19 <b>62</b> , and that death occurred at <b>11:45</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Robert Sasscer</b>				22b. DATE SIGNED <b>P.M. MAR 21 '62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert Sasscer</b>				22d. ADDRESS <b>R.F.D. Box 2150, Upper Marlboro, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>3-16-62</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hospital Cheverly, Maryland</b>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b>				25a. REC'D BY REGISTRAR <b>MAR 21 '62</b>			
				25b. REGISTRAR'S SIGNATURE <b>Wm. S. Thuma</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03673

03668

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Pr. Geo's</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> h. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thelma A. Perrie</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29 1918</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Mervin Norfolk</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Eleanor Norfolk</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. INFORMANT <b>Mrs. Eleanor Rollins-Greenbelt, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Arterio sclerosis of the Occl. Artery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterio sclerosis of the Ht. Artery</b> DUE TO (b) <b>Unknown</b> DUE TO (c) <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Pregnancy</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1961</b> to <b>Mar 3 1962</b> , that (I) (we) last saw the deceased alive on <b>3 Mar 1962</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert B. Sasscer, M.D.</b>		22b. DATE SIGNED <b>3/4/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M.D.</b>		22d. ADDRESS <b>Upper Marlboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/7/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Upper Marlboro Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-</b>		25. REC'D BY REGISTRAR <b>DATE MAR 9 '62</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

036774

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03669

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE South Carolina b. COUNTY SUMMER			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sumter			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 36 Chestnut Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ABNEY GLENN PERRY				4. DATE OF DEATH March 23 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 27, 27 34	
9. AGE (In years last birthday) 34		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Kelly Motor Lines			
11. BIRTHPLACE (State or foreign country) Mississippi				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME ERMON PERRY				14. MOTHER'S MAIDEN NAME MYRTLE ARD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. II UNKNOWN			
17. INFORMANT Billy Perry				Address Highland, New Jersey			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X Conditions, if any, which gave rise to immediate cause (b) Fracture of the skull, crushed chest (a), stating the underlying cause last. (c) compound fracture of the right hip				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by an automobile			
20c. TIME OF INJURY Month, Day, Year Hour XXX 8:50 p.m. 3/23 19 62				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 1				20f. (City or town) Laurel P. G. Md			
20g. (County)				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 3/24/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-27-62			
22c. NAME OF CEMETERY OR CREMATORY W. W. Chambers & Co Riverdale Md				22d. LOCATION (City, town, or country) Sumter S. Carolina			
23. FUNERAL DIRECTOR				24e. REC'D BY REGISTRAR MAR 27 '62			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kiana			

MEDICAL CERTIFICATION

03082

10877



Photograph of the  
in corner of the small, ornate chest  
of wood, resting on the right side

Photograph of the chest in corner of

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03675

Item 9 Film 0310 4/2/62 mh

CERTIFICATE OF DEATH

03670

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>46 Brentwood</b> d. STREET ADDRESS <b>3712 Taylor Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edgar M. Poole, Sr.</b>		4. DATE OF DEATH Month Day Year <b>March 23 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1886</b>
9. AGE (In years last birthday) <b>76 77</b> YES		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. FATHER'S NAME <b>Warner S Poole</b>		14. MOTHER'S MAIDEN NAME <b>Ella Orme</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 22 7988A</b>	
17. INFORMANT <b>Edgar M Poole Jr Brentwood Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Myocardial Fibrosis</b> DUE TO <b>Coronary Arteriosclerotic Heart Disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4-20</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b> <b>years</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-20</b> , 19 <b>62</b> to <b>3-23</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3-23</b> , 19 <b>62</b> , and that death occurred at <b>4:05</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David S. Clayman</b> M.D.		22b. DATE <b>3/25/62</b> SIGNATURE <b>A.M.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. David S. Clayman</b>		22d. ADDRESS <b>6311 Balto. Ave - Riverdale, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar 26, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Colmar Manor Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 29 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
FOR STATE  
HEALTH DEPT.

03676

03671

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Alabama b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN TB 21 Hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Haleyville 40x.3			
f. STREET ADDRESS P.O. Box #3				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Franklin D Postell				4. DATE OF DEATH March 8th., 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1936 26 yrs.	
9. AGE (in years last birthday) 26		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exercise Boy				10b. KIND OF BUSINESS OR INDUSTRY Race Track			
11. BIRTHPLACE (State or foreign country) Alabama				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Otto Postell				14. MOTHER'S MAIDEN NAME Beatrice Hylsey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT George E. Sisson				Address Alabama P.O. Box #3 Haleyville,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture skull & left wrist DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile that ran off road			
20c. TIME OF INJURY Month, Day, Year Hour X. 9:40 p.m. Mar. 7, 19 62				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 197				20f. (City or town) Laurel P.C. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				M.D. JAMES I. BOYD, M.D.			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-12-1962			
22c. NAME OF CEMETERY OR CREMATORY THORN HILL CEMETERY				22d. LOCATION (City, town, or country) (State) MARION COUNTY, ALABAMA			
23. FUNERAL DIRECTOR W.W. CHAMBERS Co. Riverdale Md.				24a. REC'D BY REGISTRAR DATE MAR 14 '62			
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The attending physician and the funeral director must completely filled in by the attending physician and the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MEDICAL CERTIFICATION

03672  
03672

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Landover Hills</b> d. STREET ADDRESS <b>7433 Parkwood Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary M. Pugh</b>		4. DATE OF DEATH Month Day Year <b>March 2 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-22-01</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>60</b>	11. IF UNDER 24 HRS. Hours Min. <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Mulloly</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lynch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217 10 7861</b>	
17. INFORMANT <b>William M. McGinnis Same as #2 (Son)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma of the rectum</b> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>2 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> to <b>2/13</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>2/5</b> 19 <b>62</b> and that death occurred at <b>2:55 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John Kehoe M.D.</b>		22b. DATE SIGNED <b>P.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John Kehoe</b>		22d. ADDRESS <b>6300 Riverdale Road, Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/5/62</b>	23c. NAME OF CEMETERY OR CREMATION <b>Gate of Heaven</b>	23d. LOCATION (City, town or county) (State) <b>Wheaton Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Aschi Soro Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 7 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03678 CERTIFICATE OF DEATH 03673										
1. PLACE OF DEATH a. COUNTY Prince George's <del>Morristown</del> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Hyattsville b. COUNTY PG County					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Maryland			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 61 5403 37th Ave.			d. STREET ADDRESS 1 Hyattsville Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last James C. Reeves					4. DATE OF DEATH Month Day Year 3 20 1962					
5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1886		9. AGE (In years last birthday) 75 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Plate Printer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME James C. Reeves					14. MOTHER'S MAIDEN NAME Mary A. Fraser					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-12-9092A		17. INFORMANT James C. Reeves			Address 9700 Riggs Rd. Adelphi, Md. (son)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) Acute pulmonary edema Arteriosclerosis Obstructive Disease								INTERVAL BETWEEN ONSET AND DEATH 3 hr. 15 yrs. 15 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20c. TIME OF INJURY Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-17 1962, to 3-20 1962, that (I) (we) last saw the deceased alive on 3-20 1962, and that death occurred at 9:50 AM, from the causes and on the date stated above.										
22a. SIGNATURE R.D. Banes M.D.					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-20-62	
22c. PHYSICIAN'S NAME (Type) R-D. Banes M.D.					22d. ADDRESS 2513 One Nudge Road Adelphi, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City, town or county) (State) Suitland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons					ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 27 '62		25b. REGISTRAR'S SIGNATURE C. S. Kline	



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Dec. 17, 1886

U.S. State Printer

U.S. Government Washington D.C.

James C. Reeves

Henry J. Reeves

and

579-12-0025A James C. Reeves

9700 2500 100 (son)  
Annapolis, Md.

Serial

3,23,65

Cedar Hill

England

Francis C. Reeves's Sons

Hyattsville, Md.



03679

CERTIFICATE OF DEATH

Reg. Dist. No. 03674

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4010-29th Street</u>		d. STREET ADDRESS <u>4010-29th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Ann</u> Last <u>Richards</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1868</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Edward A. Richards</u> (Address same as above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>56</u> , to <u>March 31</u> , 19 <u>62</u> and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard L. Whelton</u> M.D.		DATE SIGNED <u>3-31-62</u>	
PHYSICIAN'S NAME (Type) <u>Richard L. Whelton</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/3/1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

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1937

CERTIFICATE OF DEATH

1937

Name of Deceased		Date of Death	
John Doe		1937	
Age		Sex	
35		Male	
Cause of Death		Place of Death	
Heart Disease		Home	
Time of Death		Signature of Physician	
10:00 AM		[Signature]	
Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. The certificate should be signed by the Medical Examiner or the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03675

1. PLACE OF DEATH e. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>Ardmore Road, Box 263</b>	
3. NAME OF DECEASED (Type or print) <b>Albert Byrd</b>		4. DATE OF DEATH <b>March 14, 1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1882</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Ridgeway</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Lucille Ridgeway</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>no</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Forestville, Maryland</b>	
23. FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale, Md</b>		24a. REC'D BY REGISTRAR <b>19 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>3/14/62</b>	

02873



Prison Records, General Hospital, 1700 Ave Road, Box 203, Los Angeles, California

Male, White, 5'10", 175 lbs, Brown Eyes, Brown Hair, Single, 35 years old, born 10-15-1900, Los Angeles, California

James Edward, 1700 Ave Road, Box 203, Los Angeles, California

James Edward, 1700 Ave Road, Box 203, Los Angeles, California

James Edward, 1700 Ave Road, Box 203, Los Angeles, California

03681

## CERTIFICATE OF DEATH

03676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Telegraph Road</b>		d. STREET ADDRESS <b>Telegraph Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Ri</b> Last <b>edel</b>		4. DATE OF DEATH Month <b>Mar</b> Day <b>7</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/82</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Own Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Ellwein</b>		14. MOTHER'S MAIDEN NAME <b>Christina Dockler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Jacob F. Riedel same as #2 (Husband)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Artery Arteriosclerosis</b> DUE TO <b>Generalized Arteriosclerosis</b> (c) <b>CVA - Rthromiplegia 2/16/53.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>CVA - Rthromiplegia 2/16/53.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>53</b> to <b>Mar 7</b> , 19 <b>62</b> that I lost saw the deceased alive on <b>Mar 3</b> , 19 <b>62</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>RFD Glenn Dale Md 3/7/62</b>	
ACTUAL SIGNATURE <b>H James Kurtz</b>		M.D. <b>RFD Glenn Dale Md</b>	
PHYSICIAN'S NAME (Type) <b>H James Kurtz</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/9/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Church</b>	22d. LOCATION (City, town, or county) (State) <b>Bowie, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 9 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03682  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03677

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>52</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6508 Red Top Road</b>		d. STREET ADDRESS <b>6508 Red Top Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Luis</b> Middle <b>Rivera</b> Last <b>Rivera</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/1892</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- State Dept.-U.S.Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mexico</b>	
11. BIRTHPLACE (State or foreign country) <b>Mexico</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Manuel Rivera</b>		14. MOTHER'S MAIDEN NAME <b>Nariana Rosas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-52-2940</b>	
17. INFORMANT <b>Mr. Robert Gray--</b>		Address <b>6508 Red Top Road W. Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS - MYOCARDIAL INFARCTION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>MANY YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <b>1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB 8</b> 1962 to <b>MAR 18</b> 1962 that (I) (we) last saw the deceased alive on <b>MAR 16 1962</b> and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul A. DeVore</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>PAUL A. DEVORE</b>		22b. DATE SIGNED <b>301 HAMILTON ST Hyattsville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/21/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Christian Brothers</b>		23d. LOCATION (City, town, or county) (State) <b>Ammendale, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co.-2901 14th St., N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 21 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03683

## CERTIFICATE OF DEATH

03678

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>37 Landover Hills</b> d. STREET ADDRESS <b>7112 Allison Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <b>EULA E. RUTLEDGE</b>				<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>15</b> Year <b>19 62</b>													
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10-20-1896</b>		<b>9. AGE</b> (In years last birthday) <b>65</b> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>											
<b>13. FATHER'S NAME</b> <b>Albert E. Rutledge</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret A. Causey</b>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <b>Clifton E. Causey Same as #2 (Brother)</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Right Intracerebral Hemorrhage</b> DUE TO (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 years</b>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1952</b> <b>to</b> <b>3/15</b> , 19 <b>62</b> , that (I) <b>( )</b> last saw the deceased alive on <b>3/14</b> , 19 <b>62</b> , and that death occurred at <b>8:05 A.M.</b> , from the causes and on the date stated above,																	
<b>22a. SIGNATURE</b> <b>F. E. Musser</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>F. E. Musser</b>				<b>22d. ADDRESS</b> <b>441024 - Landover Hills Md.</b>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/17/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ft. Lincoln</b>		<b>23d. LOCATION</b> (City, town or county) <b>Colmar Manor, Md.</b>		<b>(State)</b>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis Gasch's Sons</b>				<b>ADDRESS</b> <b>Hyattsville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>WAR 19 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanna</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03678

CHURCHILL C. D. 1911

03678



Prince George's County, Maryland

Cherry Hill  
The Albion School  
The Albion School

March 1911

10-20-1911

North Carolina

Albert H. Rutledge  
Margaret A. Conner

CLinton E. Conner, same as #2 (Brother)

Machine right interlocked Hemlockite  
Hugobon's Hemlockite, first issue

Francis George's Sons, Hyattsville, Md.

Conner, Margaret

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03679

03684

<b>1. PLACE OF DEATH</b> e. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> c. LENGTH OF STAY IN 1b <u>adm. 3-14-1956</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAUREL SANITARIUM</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>716 CORREGE PARK</u> d. STREET ADDRESS <u>14801 CARVERT STREET</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>GUSTAVIA - VIOLA - RYAN</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>3 20 1962</u> Month Day Year			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAY 6 - 1896</u> <sup>65</sup> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>ALONZA DARCY</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>KATE V. FRYE</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>216 40 6476</u>		<b>17. INFORMANT</b> <u>Hosp. Records LAUREL SANITARIUM</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral haemorrhage (331)</u> (b) <u>arterial arteriosclerosis + dementia (334)</u> (c) <u>antecedent heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>antecedent heart disease</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 1956</u> <b>to</b> <u>MARCH 20, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>MARCH 20, 1962</u> <b>and that death occurred at</b> <u>5:15</u> <b>M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Erika P. Kraemer</u> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3-20-62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ERIKA P. KRAEMER</u>				<b>22d. ADDRESS</b> <u>LAUREL SANITARIUM LAUREL Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/22/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Epithany Episcopal Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Forestville, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Pasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>MAR 27 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. The State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**03685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03680**

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5643 Shadyside Avenue</b>				d. STREET ADDRESS <b>5643 Shadyside Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>CHESTER ROSS RYON</b>				4. DATE OF DEATH <b>March 13 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 25, 1902</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sightseeing-Hacker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sightseeing</b>			
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>ROSS WILLIAM RYON</b>				14. MOTHER'S MAIDEN NAME <b>HARRIET ANN SUMMERS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W.W.II</b>				16. SOCIAL SECURITY NO. <b>579-16-4701</b>			
17. INFORMANT <b>Roger William Conway, Jr.</b>				Address <b>3422 Rutgers St. University Hills, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Carbon monoxide poisoning</b>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ran hose from exhaust into car</b>			
20c. TIME OF INJURY Month, Day, Year <b>6:20 p.m. 3-13-62</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Public Car</b>		20f. (City or town) (County) (State) <b>Suitland P.g. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>W. W. Chambers Co</b>				24a. REC'D BY REGISTRAR <b>Arthur S. Kline</b>			
				24b. REGISTRAR'S SIGNATURE			
				DATE <b>MAR 19 '62</b>			

MEDICAL CERTIFICATION

2

03220

03220



Best Carbon copy of  
copy of

For further information  
see page 12 of 13

James J. Doyle

1940 I. 1000

3-14-40  
of the

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03688

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03681

Items 22c & d, 'phone call from fun.dir.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> <b>✓</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Foote</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Congress Heights</b> <b>47X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Webster's Boat Yard</b>		d. STREET ADDRESS <b>809 Portland Street S. E.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Irving Leroy Sandy Jr</b>		4. DATE OF DEATH Month Day Year <b>March 24 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1937</b>
9. AGE (In years last birthday) <b>24 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>24</b>	
11. IF UNDER 24 HRS. Hours Min. <b>19</b>		12. IF UNDER 24 HRS. Hours Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Irving Leroy Sandy Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Mae Violet</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 56-57</b>		16. SOCIAL SECURITY NO. <b>577-52-8537</b>	
17. INFORMANT <b>Michele Kathleen Sandy, same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b>			
DUE TO (b) <b>Drowning</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from a boat into the river</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:55xx 3/24/19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Potomac River</b>		20f. (City or town) (County) (State) <b>Fort Foote P. G. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>3/24/62</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/28-1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL</b>		22d. LOCATION (City, town, or country) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR <b>W.W. CHAMBERS Co</b>		24a. REC'D BY REGISTRAR <b>517-112 St SE WASH DC</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		24c. DATE <b>MAR 29 '62</b>	

1945

1945

1

Washington, D.C.  
January 1, 1945  
Dear Mr. [Name]  
I am very pleased to hear from you and to learn that you are well and happy. I hope you are enjoying the winter weather. I am still in the city and working on my projects. I will be in touch with you again soon. Please write back when you have a chance. I am looking forward to hearing from you.  
Very truly,  
[Signature]  
[Name]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/62

03687  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03682

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 01 Laurel			
c. LENGTH OF STAY IN lb				d. STREET ADDRESS 1 35 A Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANDREW SAFFELL SEALOCK				4. DATE OF DEATH March 9, 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1898 63 yrs.	
9. AGE (In years last birthday) 63		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Tender		10b. KIND OF BUSINESS OR INDUSTRY Mineral Pigments		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dorsey Sealock		14. MOTHER'S MAIDEN NAME Martha Kearns		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No None	
16. SOCIAL SECURITY NO. 223-24-2872		17. INFORMANT Mrs. Stella M. Sealock,		Address 35 A Street		Laurel, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hemorrhage and Shock							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Gunshot wound in the head							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Shot self through head							
20c. TIME OF INJURY Month, Day, Year 3:43 p.m. Mar. 9, 1962							
20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) In Auto Laurel, Prince Geo. Cty., Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd							
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 3/12/62							
22c. NAME OF CEMETERY OR CREMATORY 104 Hill Cemetery							
22d. LOCATION (City, town, or country) (State) Laurel, Prince Geo. Co. Md.							
23. FUNERAL DIRECTOR ADDRESS 254 Carroll St NW							
24. REC'D BY REGISTRAR DATE MAR 14 '62							
24b. REGISTRAR'S SIGNATURE Arthur S. Hana							

DATE SIGNED  
3/9/62.

11

Shaw

Local

Private

John Memorial Hospital

to a local

Barney

Barney

June 25, 1952

White

Other

General

North Korea

Barney

None

Remains and goods

Remains found in the field

Barney found

Barney found

Barney found

Barney found

Barney found



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03688

## CERTIFICATE OF DEATH

03683

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Suitland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3218 Sycamore ave</u>		d. STREET ADDRESS <u>1 3218 Sycamore ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Austin</u> Middle <u>L</u> Last <u>Shaw</u>		4. DATE OF DEATH <u>3-9-62</u> 19 <u>62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4 - 1902</u>
9a. AGE (In years, months, days) <u>64</u> yrs.		9b. IF UNDER 1 YEAR <u>64</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S.G.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>clerk</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Justin Shaw</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dickson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-20-0195</u>	
17. INFORMATION <u>d. Madeline Hayden</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X</u> DUE TO <u>congestive failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>myocardial failure</u>		(b) <u>2 year</u>	
(c) <u>rheumatic cardiac disease</u>		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>coronary arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 5th</u> , 19 <u>62</u> to <u>Mar 9th</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Mar 8</u> , 19 <u>62</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James J. Goadley</u>		22b. DATE SIGNED <u>Mar 9 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M. Lee &amp; Sons</u>		22d. ADDRESS <u>401 Nichols ave NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-12-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Lee &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>Mar 14 62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

03880

03880

(M)

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Quentin", "Clark", and "March" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, portions should be detached for use as the burial-transit permit. Then please remove carbon papers. Portions 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03689

## CERTIFICATE OF DEATH

Reg. Dist. No. 03684

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>14 yrs. 11 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Home</b>		d. STREET ADDRESS <b>2013 Hayden Road, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>A</b> Last <b>Shea</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1864</b>
9. AGE (In years last birthday) <b>98</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>John Rooney</b>		14. MOTHER'S MAIDEN NAME <b>Ann Agnes Atkinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sacred Heart Home, W. Hyattsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Congestive Heart Failure</b> DUE TO (b) <b>Chronic Cardiac Vascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 Jan 62</b> to <b>27 Feb 62</b> , that I last saw the deceased alive on <b>27 Feb 62</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William C. Hall</b> M.D.		DATE SIGNED <b>25 Mar 1962</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-6-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		ADDRESS <b>3821-14th St. N.W. Wash. D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 6 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hixson</b>	



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VR A15 (4)  
15M 9/60

M

90

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03690					03685									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY Prince Georges MARYLAND					e. STATE D.C. b. COUNTY									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Adelphi					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington									
c. LENGTH OF STAY IN 1b 1 1/2 wks.					47X-3									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Paint Branch Nursing Home					d. STREET ADDRESS 539 Webster St., S.E.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last					4. DATE OF DEATH Month Day Year									
Eitz (none) Shipman					March 21 1962									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 31, 1874		9. AGE (In years last birthday) 87 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME (21 unknown) Sincos					14. MOTHER'S MAIDEN NAME Not known									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Address Nursing Home Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH 4 Days				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bronchial														
471X DUE TO														
Conditions, if any, which gave rise to immediate cause (b)														
(c), stating the underlying cause last. DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Diabetes Mellitus														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from March 15, 1962 to March 21, 1962, that (I) (we) last saw the deceased alive on March 18, 1962, and that death occurred at 2:00 PM, from the causes and on the date stated above.														
22a. SIGNATURE Stuart L. Nelson					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-21-62					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF March 24, 1962		23c. NAME OF CEMETERY OR CREMATORY Walker Chapel Cem.		23d. LOCATION (City, town or county) Arlington, Virginia		(State)						
24. FUNERAL DIRECTOR'S SIGNATURE J. C. Gray -					ADDRESS 2847 Wilson Blvd., Arlington, Va.		25a. REC'D BY REGISTRAR DA MAR 23 '62		25b. REGISTRAR'S SIGNATURE					

08082

08080

(M)

March 2, 1965 Walker Canal Com. Arlington, Va.  
Last Wilson Blvd., Arlington, Va.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03691  
CERTIFICATE OF DEATH  
03687

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>31 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baden</b> d. STREET ADDRESS <b>P.O. Baden</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas E. Simms</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>65</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. William Simms</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gray</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> <b>Josephine Simms</b> Address <b>Brandywine, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4 20 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Fibrosis</b> DUE TO (c) <b>Coronary Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-27</b> , 19 <b>62</b> to <b>3-30</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3-30</b> , 19 <b>62</b> , and that death occurred at <b>10:00</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>David S. Clayman</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. ADDRESS <b>6311 Baltimore Ave., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/4/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter</b>		23d. LOCATION (City, town or county) (State) <b>Waldore Chr. County Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George H. Nelson</b>		25a. REC'D BY REGISTRAR <b>APR 6 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

(M)

1947

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03692

CERTIFICATE OF DEATH

03689

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND 20</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17 DUVAL ST</u>				d. STREET ADDRESS <u>17 DUVAL ST</u>			
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>ELLEN</u> Last <u>SITES</u>				4. DATE OF DEATH Month <u>MAR.</u> Day <u>14</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21-1884</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>JOHN MOORE</u>			14. MOTHER'S MAIDEN NAME <u>MARY DAUGHERTY</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ROBERT M SITES</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>15 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1961</u> to <u>March 14, 1962</u> that (I) (we) last saw the deceased alive on <u>March 13, 1962</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>Thos. F. Cleary MD</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-14-62</u>		
22c. PHYSICIAN'S NAME (Type) <u>Thos. F. Cleary MD</u>			22d. ADDRESS <u>5558 Silver Hill Rd Wash 28, D.C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-17-62</u>			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>EAST HILL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>SALEM VA.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME WASH. D.C.</u>			ADDRESS		25a. REC'D BY REGISTRAR DATE <u>MAR 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

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(M)

George & Grace

Mrs

Guinevere

13 Darnley St. to Darnley St

1885

May 21/1885 to

Victoria

John Moore

Forest of Dean

George & Grace  
Remedy for rheumatism

Dr. J. C. Williams

April 14th 1885

Thos. F. Chesty M.D.  
Thos. F. Chesty M.D.

1885

1885

Thos. F. Chesty M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03693 CERTIFICATE OF DEATH 03690

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Laurel 02 BANDMILL Rd. 1	
3. NAME OF DECEASED (Type or print) First Middle Last Larry TILLMAN Smith		4. DATE OF DEATH Month Day Year March 31 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17-35
9. AGE (In years last birthday) 26 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY-DOY CLEANING		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS	
11. BIRTHPLACE (County & State, or foreign country) NASHVILLE TENN		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME TILLMAN H. SMITH		14. MOTHER'S MAIDEN NAME FRANCES G. GIBSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590X DUE TO Uremia (b) DUE TO Acute Glomerulonephritis (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Polyostotic Fibrous Dysplasia of Bone			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-25-62, 19 62 to 3-31-62, 19 62, that (I) (we) last saw the deceased alive on 3-31-19 62, and that death occurred at 1:00 P.M. the causes and on the date stated above.			
22a. SIGNATURE John R. Buell		22b. DATE SIGNED M.D. 22d. ADDRESS 550 WASH BLVD, LAUREL, MD.	
22c. PHYSICIAN'S NAME (Type)		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 3, 1962	
23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEM.		23d. LOCATION (City, town or county) (State) ELKRIEVE HOWARD CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE 550 WASH BLVD, LAUREL, MD.		25a. REC'D BY REGISTRAR DATE APR 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

02880

CERTIFICATE OF DEATH

02880

M

James H. Smith  
Francis E. Gibson  
James H. Smith  
Francis E. Gibson

7 days  
7 days  
7 days  
7 days

Acute primary disease  
Disease  
Acute inflammation  
Polymorphic virus lymphoma of bone

*[Signature]*

James H. Smith  
Francis E. Gibson  
James H. Smith  
Francis E. Gibson



03691

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>11 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellsville</b> d. STREET ADDRESS <b>Enterprise Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edward Carl Sokolowski</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>17</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1898</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		11. IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>educator U.S. Vet Adm.</b>				11. BIRTHPLACE (State or foreign country) <b>Tarnow, Poland</b>			
13. FATHER'S NAME <b>Karl Sokolowski</b>				14. MOTHER'S MAIDEN NAME <b>Anna Helena Zielinski</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>				16. SOCIAL SECURITY NO. <b>577-58-5836</b>		17. INFORMANT <b>Mrs. Irene Doda Sokolowski, Wife</b> Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhagic Infarct</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Cerebral Atherosclerosis</b> DUE TO (c) <b>Generalized Atherosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>years</b> <b>years</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Hypertensive Atherosclerotic Heart Disease</b>				20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. (City or town)				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 1957</b> to <b>3/17</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> 19 <b>62</b> and that death occurred at <b>12 M.</b> from the causes and on the date stated above.				22a. SIGNATURE <b>H. James Kurtz</b> M.D. 22b. ADDRESS <b>RFD Glenn Dale Md</b>			
22c. PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>				22d. DATE SIGNED <b>3/17/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/20/62</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>				23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 21 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Glenn D. Doda</b>							

14

1900

CERTIFICATE OF DEATH

1900

John Doe  
Born [illegible]  
Died [illegible]  
Cause of Death [illegible]  
Buried [illegible]  
Witnesses [illegible]  
Minister of the Gospel [illegible]  
Signature [illegible]  
Date [illegible]

1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03692

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills 37			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 6917 Varnum St.			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM JAMES RUDOLPH SPAHR				4. DATE OF DEATH March 23 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Dec. 30, 1891	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired*Prop. Clk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OSCAR G.E. SPAHR				14. MOTHER'S MAIDEN NAME MARIE GUARTZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 17. INFORMANT Mildred H. Spahr Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes for last four years							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER			
EXAMINER'S NAME (Type) JAMES I. BOYD				ASSISTANT MEDICAL EXAMINER			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 3/24/62			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/26/62		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cent. Blandsburg, Md		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR J. W. Lee Wash. D. C.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur E. Harris	
				DATE MAR 28 '62			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 2 should be retained for your files. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR E  
SM 1/62

03885



*James D. [unclear]*  
*James D. [unclear]*  
*James D. [unclear]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY <b>PRINCE GEORGE</b>												2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>Howard</b>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>												c. LENGTH OF STAY IN 1b <b>adm 3-8-62</b>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>LAUREL SANITARIUM</b>												d. STREET ADDRESS <b>FULTON LIME KIRK ROAD</b>											
3. NAME OF DECEASED (Type or print) <b>ERLA E SPENCER</b>												4. DATE OF DEATH <b>3 12 19 62</b>											
5. SEX <b>Female</b>												6. COLOR OR RACE <b>WHITE</b>											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <b>December 13-1876</b>											
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>housewife</b>												10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>											
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>												12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>JOHN F. STAUB</b>												14. MOTHER'S MAIDEN NAME <b>MARK BLONDER</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NONE</b>												16. SOCIAL SECURITY NO. <b>unknown</b>											
17. INFORMANT <b>Hosp. Records</b>												Address <b>LAUREL SANITARIUM</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>433.1</b> DUE TO <b>Cardiac fibrillation (433.1)</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>myocardial degeneration with arterio sclerosis (422.1)</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>												19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <b>19 62</b> Hour a.m. <b>3-8-</b> p.m. <b>3-12-</b>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>3-8-62</b> to <b>3-12-62</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3-12-62</b> and that death occurred at <b>1:20pm</b> from the causes and on the date stated above.												22a. SIGNATURE <b>Linda P. Kraemer</b> M.D. <b>3-12-62</b>											
22c. PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>												22b. ADDRESS <b>LAUREL SANITARIUM, LAUREL Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>												23b. DATE THEREOF <b>March 15, 1962</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>St. Louis Cemetery</b>												23d. LOCATION (City, town or county) (State) <b>Clarksville, Howard Co., Md.</b>											
24 FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>												25a. REC'D BY REGISTRAR <b>Mar 15 '62</b>											
25b. REGISTRAR'S SIGNATURE <b>Raymond A. Z...</b>												25c. REGISTRAR'S SIGNATURE <b>...</b>											

(M)

(I)

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PRINTED GEORGE

SALES 3-8-64

SALES DISTRIBUTION

3-12-64

December 1964

MARKETING

MARKETING

John F. Sturges

SALES DISTRIBUTION

SALES DISTRIBUTION

SALES DISTRIBUTION

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3-8-64

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John F. Sturges

SALES DISTRIBUTION

March 15, 1964

SALES DISTRIBUTION

SALES DISTRIBUTION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03697

03694

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Ranier</b> d. STREET ADDRESS <b>4008 - 81st. Ave.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>18 Days</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Maggie M. Stansbury</b>				4. DATE OF DEATH Month Day Year <b>March 11 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 8, 1873</b>	
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>James E Withers</b>			
14. MOTHER'S MAIDEN NAME <b>Priscella A Jerman</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Norma S Williams Mt Rainier Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>17.5.0</b> DUE TO (b) <b>Bil or Carc. of the Ovary</b> Conditions, if any, which gave rise to immediate cause (c) <b>heart failure chronic</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>inner algea Arterio sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>6 months</b> <b>1 week</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-22-62</b> to <b>3-11-62</b> , that (I) (we) last saw the deceased alive on <b>3-11-1962</b> , and that death occurred at <b>10:15 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon R. Levitsky</b> M.D.				22b. DATE SIGNED <b>10-15-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Leon R. Levitsky</b>				22d. ADDRESS <b>3408 Rhode Island Ave., Mt. Ranier, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 15, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington D C</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	

08651

08651



*Handwritten text, likely a signature or title, appearing upside down.*

10:1

*Handwritten signature or name.*

*Handwritten text at the bottom of the page, possibly a date or reference.*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03698

## CERTIFICATE OF DEATH

03695

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>23 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL ANDREWS</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>BOLLING AIR FORCE BASE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>74 WESTOVER AVENUE</b> d. STREET ADDRESS <b>47X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JULIA</b>		First <b>T</b> Middle <b>STROTHER</b>		Last <b>STROTHER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 SEPTEMBER 1899</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b>		IF UNDER 24 HRS. Days <b>62</b>		Hours <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BATESVILLE, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY <b>UNITED STATES</b>	
13. FATHER'S NAME <b>T. W. TAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>MARIG MOON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>DEAN C STROTHER (HUSBAND)</b> Address <b>SAME AS ITEM #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>EMPHYEMA, LEFT THORAX</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH
21. I certify that (I) (do not use) attended the deceased from <b>23 FEBRUARY 1962</b> to <b>18 MARCH 1962</b> , that (I) (do not use) saw the deceased alive on <b>18 MARCH 1962</b> , and that death occurred on <b>18 MARCH 1962</b> , from the causes and on the date stated above.							
22e. SIGNATURE <i>Albert D Carilli</i> M.D. 22c. PHYSICIAN'S NAME (Type) <b>ALBERT D CARILLI, Capt USAF MC</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>USAF HOSP, ANDREWS AIR FORCE BASE, MD</b>		22b. DATE SIGNED <b>18 MAR 62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-21-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL</b>		23d. LOCATION (City, town or county) (State) <b>FT MYER VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i> ADDRESS <b>3072 N St NW</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 21 '62</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

HOSYAT, W. T.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

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03699

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03696

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			b. COUNTY Prince Georges		
c. LENGTH OF STAY in lb 5 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47th. Ranier		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRINCE GEORGES GENERAL HOSPITAL			d. STREET ADDRESS 3717 - 36th. St.		
3. NAME OF DECEASED (Type or print) First Harry Middle B. Last Sturgis			4. DATE OF DEATH Month 3 Day 5 Year 19 62		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-00		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector, Pr. Georges Co. Health Dept. Washington, D.C.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) U.S.	
13. FATHER'S NAME Thomas Harry Sturgis		14. MOTHER'S MAIDEN NAME Maude M. Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes - 1919-1923 & 1927-1928		16. SOCIAL SECURITY NO. 1928		17. INFORMANT Margaret V. Sturgis, Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lt 28 1/2 DUE TO (b) Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 + months 5 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-21-1962 to 3-5-1962, that (I) (we) last saw the deceased alive on 3-5-1962, and that death occurred at 5:00 AM, from the causes and on the date stated above.					
22a. SIGNATURE Waldo B. Moyers		22b. PHYSICIAN'S NAME (Type) Waldo B. Moyers		22c. DATE SIGNED MAR 12 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/62		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington, Va.		23e. REC'D BY REGISTRAR MAR 12 '62		23f. REGISTRAR'S SIGNATURE Arthur L. Evans	
24. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home, Inc.					

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THE STATE OF TEXAS

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Accepted for deposit  
this 1st day of January  
1900 by the  
County Clerk of  
the County of  
Texas.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove call papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03700  
CERTIFICATE OF DEATH  
03697

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>64 Hyattsville</b> d. STREET ADDRESS <b>6917 Oakridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Walter</b> First <b>C.</b> Middle <b>Summer</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 62</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-85</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Army Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Benjamin R. Summer</b>			14. MOTHER'S MAIDEN NAME <b>Ida May Dewey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I and II</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charlotte C. Summer Same as #2 (Wife)</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Coronary Artery Thrombosis</b> DUE TO (b) <b>Arteriosclerosis Heart Disease</b> DUE TO (c) <b>Partial Intestinal obstruction (due to malrotation left descending colon)</b> INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>None</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1961</b> , to <b>3-5</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3-5</b> , 19 <b>62</b> , and that death occurred at <b>9:45</b> M, from the causes and on the date stated above.						
22a. SIGNATURE <b>Donald C. Edgren</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-6-62</b>
22c. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGREN</b>				22d. ADDRESS <b>35-00 East-West Highway Hyattsville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 8, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town or county) <b>Colmar Manor, Md.</b> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Finner</b>

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Prince George's County, Maryland

Charter of the Prince George's County Board of Health

Section 1. The Board of Health of Prince George's County, Maryland, is hereby organized and constituted.

Section 2. The Board of Health shall consist of five members, to be appointed by the Board of Commissioners.

Section 3. The Board of Health shall hold its first meeting on the first day of January, 1900.

Section 4. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

Section 5. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

Section 6. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

Section 7. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

Section 8. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

Section 9. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

Section 10. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

Section 11. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

Section 12. The Board of Health shall have the honor and pleasure of the County, and shall exercise all the powers and perform all the duties conferred upon it by the Board of Commissioners.

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03698

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Glen Arden Heights	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 1505 3rd Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Veda Clara Swann		4. DATE OF DEATH Month Day Year March 10 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days 10 16	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (State or foreign country) District of Columbia		14. CITIZEN OF WHAT COUNTRY U. S. A.	
15. FATHER'S NAME Hans Bowdwin		16. MOTHER'S MAIDEN NAME Annie	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. none	
19. INFORMATION Address William Henry Swann, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED March 10, 1962	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 14-1962	
22c. NAME OF CEMETERY OR CREMATORY Harmony Cem - Pr Geo Co - Md -		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR William Spangler		24a. REC'D BY REGISTRAR 524-8-ST NE DC DATE MAR 12 '62	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other is necessary, use the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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General

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville			
c. LENGTH OF STAY IN lb 1 hr				d. STREET ADDRESS 3120 Powder Mill Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Zita Frances Swift				4. DATE OF DEATH Month Day Year March 25 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1884	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Thomas Coons				14. MOTHER'S MAIDEN NAME Mary Bender			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-18-0424			
17. INFORMANT Thomas Coons				Address Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 9020 Conditions, if any, which gave rise to immediate cause (b) Fracture of right hip (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor getting out of bed			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3/4/68		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Adelphi P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 3/26/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/62		22c. NAME OF CEMETERY OR CREMATORY St. Patricks		22d. LOCATION (City, town, or country) (State) Alyphant Penna	
23. FUNERAL DIRECTOR Nalleys Funeral Home, Inc.				24a. REC'D BY REGISTRAR DATE MAR 30 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

03899

03899

1. The first of these is the fact that the  
2. second is the fact that the  
3. third is the fact that the

4. fourth is the fact that the  
5. fifth is the fact that the  
6. sixth is the fact that the

7. seventh is the fact that the  
8. eighth is the fact that the  
9. ninth is the fact that the

10. tenth is the fact that the  
11. eleventh is the fact that the  
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13. thirteenth is the fact that the  
14. fourteenth is the fact that the  
15. fifteenth is the fact that the

16. sixteenth is the fact that the  
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19. nineteenth is the fact that the  
20. twentieth is the fact that the



13  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03703 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03700

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights				c. LENGTH OF STAY IN 1b 19 hrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2915 Fairlawn Streetx				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Eastern Easton 2029-2			
f. STREET ADDRESS 613 South Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Basil Robinson Taylor				4. DATE OF DEATH Month Day Year March 31 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sep. 29, 1899	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Norman Billieter Taylor				14. MOTHER'S MAIDEN NAME Flora Towers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-03-0729		17. INFORMANT Charles Norman Taylor, Eastern, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 Acute congestive heart failure DUE TO (b) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED March 31, 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/3/62		22c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery	
23. FUNERAL DIRECTOR W. Hampton Carroll				22d. LOCATION (City, town, or country) Preston, Maryland		(State)	
24a. REC'D BY REGISTRAR W. Hampton Carroll				24b. REGISTRAR'S SIGNATURE		DATE APR 3 '62	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any page is necessary, give page number in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03704

03701

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cottage City</b>			c. LENGTH OF STAY IN 1b <b>5 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Croom</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4005 Bunker Hill Rd</b>				d. STREET ADDRESS <b>--</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>M.</b> Last <b>Tayman</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Smith</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Wells</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Mrs. Mabel Elizabeth Thornburg- Item 1.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>3 + 4 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 + 4 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-24</b> , 19 <b>59</b> , to <b>3-25</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>3-24</b> , 19 <b>62</b> , and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Waldo B. Moyers</b> M.D.				ADDRESS (Street, city or town, state) <b>3503 Perry St., Mt. Rainier, Maryland.</b>		DATE SIGNED <b>3/25/62</b>	
PHYSICIAN'S NAME (Type) <b>Waldo B. Moyers, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/28/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Croom, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro,</b>				ADDRESS <b>Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03705 CERTIFICATE OF DEATH 03702

1. PLACE OF DEATH e. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>Rt. 2 Box 179</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Southern Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Francis Cleaverson Thompson</u>				4. DATE OF DEATH <u>March 12 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 3, 1888</u>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Prince George - Md -</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>PLIM THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE JOHNSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>YES</u>			
17. INFORMANT <u>IRENE M THOMPSON</u>				Address <u>WALDORF MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4-4-3X</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO (b) <u>Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertensive Heart disease</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1962</u> to <u>3/12/1962</u> , that (I) (we) last saw the deceased alive on <u>3-12-1962</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James M. Fadeley</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. FADELEY</u>				22d. ADDRESS <u>CLINTON MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-15-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST BARNABAS CHURCH CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>OXEN HILL, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Jr Inc</u>				ADDRESS <u>WASH, D.C. 517-11th St. S.E.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 15 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

03705

03705





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03706

03703

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 1 month and 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 d. STREET ADDRESS 5048 8th St., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Mary - Thompson <b>5. SEX</b> Female <b>6. COLOR OR RACE</b> Negro <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> 12/14/14 <b>9. AGE</b> (In years last birthday) 47 yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min. 3 22 19 62			<b>4. DATE OF DEATH</b> Month Day Year 3 22 19 62				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -		<b>11. BIRTHPLACE</b> (County & State, or foreign country) S. C.		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> Ketto Wright				<b>14. MOTHER'S MAIDEN NAME</b> Amelia Butler Wright			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) Unknown -		<b>16. SOCIAL SECURITY NO.</b> Unknown		<b>17. INFORMANT</b> Address Decedent			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary tuberculosis (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculous empyema, left; left pleuro-cutaneous fistula; left thoracoplasty; diabetes mellitus; urinary infection, etiology undetermined.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> Unknown 24 yrs.,	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from 2/21/1962 to 3/22/1962, that (I) (we) last saw the deceased alive on 3/22/1962, and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> Moe Weiss, M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> 3/22/62	
<b>22c. PHYSICIAN'S NAME</b> (Type) Moe Weiss, M.D.				<b>22d. ADDRESS</b> Glenn Dale Hospital Glenn Dale, Md.			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 3-26-62		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Carver Memorial Park		<b>23d. LOCATION</b> (City, town or county) (State) Prince Georges Co. Md.	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS 909 6th St. NW				<b>25a. REC'D BY REGISTRAR</b> DATE MAR 27 '62		<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Thomas	

M

Wm. W. W.

Wm. W. W.

Wm. W. W.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03704

03707

(M)

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(I)

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1

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL ANDREWS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>26 HILLSIDE</b> d. STREET ADDRESS <b>5501 "O" STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JEANNETTE</b> First <b>AGNES</b> Middle <b>TIERNEY</b> Last		4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 FEBRUARY 1894</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>
13. FATHER'S NAME <b>PHILIP HADEN</b>		14. MOTHER'S MAIDEN NAME <b>Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Wm. J. Tierney Sr</b>		Address <b>5501-O-St. Hillside, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3 31 X</b> DUE TO <b>cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive vascular disease</b> (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>34 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>18 MARCH 19 62</b> to <b>19 MARCH 19 62</b> , that (I) <b>XX</b> last saw the deceased alive on <b>19 MARCH 19 62</b> , and that death occurred at <b>1240P</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Albert D Carilli</b>		22b. DATE SIGNED <b>19 MAR 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT D CARILLI, Capt USAF MC</b>		22d. ADDRESS <b>USAF HOSP, ANDREWS AIR FORCE BASE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Burial March 21-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	23d. LOCATION (City, town or county) (State) <b>Southland 2nd</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sumner Bros</b>		25a. REC'D BY REGISTRAR <b>1661- gd Hope Rd S E</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Farris</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



percol.

VR A15ME  
5M 1/62

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN b <b>1 1/2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4904 43rd Street</b>		d. STREET ADDRESS <b>4904 43rd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>GLENN</b>		Middle <b>TIPPETT</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Aug. 28, 1945</b>		9. AGE (In years last birthday) <b>16</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Short Order Cook</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		13. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
14. FATHER'S NAME <b>John Arthur Tippet</b>		15. MOTHER'S MAIDEN NAME <b>Bessie Agnes Cook</b>		16. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>John Arthur Tippet, Same as #2</b>		19. INFORMANT <b>John Arthur Tippet, Same as #2</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Gun shot wound in the chest</b> DUE TO (c)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot self in the chest with a 22 Cal. rifle</b>		22. INTERVAL BETWEEN ONSET AND DEATH	
23a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in the chest with a 22 Cal. rifle</b>		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
25a. TIME OF INJURY Month, Day, Year <b>7:30 P.M. 3/25 1962</b>		25b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		25c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
25d. (City or town) <b>Hyattsville P.G., Md.</b>		25e. (County) <b>Prince George's</b>		25f. (State) <b>Md.</b>	
26. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		27. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		28. DATE SIGNED <b>3/25/62</b>	
29. ACTUAL SIGNATURE <b>James I. Boyd</b>		30. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		31. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
32. EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>		33. ADDRESS (Street, city, town, or county) <b>Washington National</b>		34. ADDRESS (Street, city, town, or county) <b>Suitland, Maryland</b>	
35a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		35b. DATE THEREOF <b>3/28/62</b>		35c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>	
35d. LOCATION (City, town, or country) <b>Suitland, Maryland</b>		36. REC'D BY REGISTRAR <b>3/29/62</b>		37. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	
38. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		39. ADDRESS <b>Hyattsville, Md.</b>		40. REC'D BY REGISTRAR <b>3/29/62</b>	
41. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		42. ADDRESS <b>Hyattsville, Md.</b>		43. REC'D BY REGISTRAR <b>3/29/62</b>	

08708

00700

1

1

Stanton's Sons, Tyngsboro, Mass.

3/28/63

Washington National

Bureau, Maryland

JAMES I. FORD

*James I. Ford*

Home

7:30 PM

Shot sent in the night with a 12.00. Title

But shot wound in the chest

Handwritten and shown

Don't let the subject, there as he

He did a great good

Now's Great Good

Handwritten

White

Handwritten

John

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03709 CERTIFICATE OF DEATH 03706

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE D.C. b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 3 days		d. STREET ADDRESS 1390 Rittenhouse St. NW	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Simon - Troshinsky		4. DATE OF DEATH 3 29 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888
9. AGE (In years last b 1 day) 74 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Sexton)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Hillel Troshinsky		14. MOTHER'S MAIDEN NAME Esther	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-50-9996	
17. INFORMANT Mrs. DORA Papier		400 Indian Head Ave. Indian Head, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident with right hemiparesis DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis; generalized arteriosclerosis; hypertensive cardiovascular disease (historical)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/26/62 to 3/29/62, that (I) (we) last saw the deceased alive on 3/29/62 and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 3/29/62	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF March 28, 1962	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CAPITAL-HEBREW CEM. Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky		25a. REC'D BY REGISTRAR DATE MAR 30 '62	
ADDRESS 3501-14 St. N.W.		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

03306

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

W 5 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03710 CERTIFICATE OF DEATH 03707

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine Md.</u> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo Co</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine, Maryland</u> d. STREET ADDRESS <u>Rt. 1. Box 356</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence L. Tucker</u> First Middle Last		4. DATE OF DEATH <u>3 2 1962</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1884</u> yrs. Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Plummer Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Downs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-38-6684</u>	
17. INFORMANT <u>Fannie T. Tucker</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Laennec's cirrhosis + massive ascites + anasarca</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>Dec 1, 1961</u> to <u>March 2, 1962</u> ; that (I) ( <u>we</u> ) last saw the deceased alive on <u>March 2, 1962</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u>		22d. ADDRESS <u>CLINTON, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 5-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>		23d. LOCATION (City, town or county) (State) <u>Bader, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros 1661-4th Ave Rd S</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 5 '62</u>	
ADDRESS <u>Wash DC</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton L. Harris</u>	

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MARYLAND

BRIDGEPORT

Rt. 1. Box 521

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03711

03708

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN b. <u>3 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Englewood Memorial Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>02 Oakcrest, Laurel</u> d. STREET ADDRESS <u>214 Linden Street</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mamie Virginia Tucker</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>March 9 1962</u> Month Day Year					
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 11, 1916</u> yrs.		<b>9. AGE</b> (In years last birthday) <u>45</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Same</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Charles Ross</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lily Palk</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Mr Norman Tucker, Laurel, Md.</u> Address <u>214 Linden St</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>Hypertension</u> (c) <u>Obesity - Worry</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>12 yr.</u> <u>15 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>6/10 1950</u> <b>to</b> <u>3/9 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3/9 1962</u> <b>and that death occurred at</b> <u>8 PM</u> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>B P Warren</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>B P WARREN</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>Laurel Md</u>				<b>22b. DATE SIGNED</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/12/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Savage Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Savage Md</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>De Witt Sanderson</u> ADDRESS <u>Laurel, Md</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Arthur L. Thomas</u> DATE <u>MAR 13 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03712

CERTIFICATE OF DEATH

03709

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE D. C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 636 I. St., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Turner 4. DATE OF DEATH Month Day Year 3 15 19 62		5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 6/1/1890 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Dingee Cheselton 14. MOTHER'S MAIDEN NAME Henerietta Cheselton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Betty Williamson Address 5129 Fisher Rd., Temple Hills, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44-3X Hypertensive and arteriosclerotic cardiovascular disease with cardiac decompensation Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic pyelonephritis, epigastric mass, etiology undetermined, diabetes mellitus, gastrointestinal bleeding, etiology undetermined.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/16/1962 to 3/15/1962, that (I) (we) last saw the deceased alive on 3/15/1962, and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22b. DATE SIGNED 3/15/62 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Mar 19-62 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill 23d. LOCATION (City, town or county) (State) South-d, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Semmons Fun Home ADDRESS 1661 Good Hope Rd. S.E. Wash. D. C. 25a. REC'D BY REGISTRAR DATE MAR 19 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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Washington

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 03710

03713

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. M.D. b. COUNTY P.E.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Madison Manor Nursing Home		d. STREET ADDRESS 6301 Kansas Ave., N.E.	
3. NAME OF DECEASED (Type or print) First SAVERIO Middle VAGNERINI Last		4. DATE OF DEATH March 26 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Barber	11. BIRTHPLACE (State or foreign country) Italy
13. FATHER'S NAME Michael Vagnerini		14. MOTHER'S MAIDEN NAME Rose Coscini	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-01-4819	17. INFORMANT Mae C Vagnerini same as above
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Cerebral aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from 3-1-62, 19, to 3-26, 1962 that I last saw the deceased alive on 3-26-62, 19, and that death occurred at 11:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum		DATE SIGNED 3-26-62	
PHYSICIAN'S NAME (Type) John P. Clum		ADDRESS (Street, city or town, state) 6110 43rd Ave Hyattsville Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-30-62	22c. NAME OF CEMETERY OR CREMATORY Rock Creek	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee		24a. REC'D BY REGISTRAR DATE MAR 28 '62	
ADDRESS 300 Hth St. N.E.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

initiated by the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03714		Item 3 Film 6311 4/23/62 mh		03711	
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HILLCREST HEIGHTS</b> d. STREET ADDRESS <b>5916 SAINT CLAIR STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>HAROLD</b> Last <b>Henry WALSH</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>29</b> Year <b>19 62</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10 NOVEMBER 1907</b>		9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>54</b> Days <b>29</b> Hours <b>19</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US AIR FORCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US AIR FORCE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			13. FATHER'S NAME <b>JOSEPH WALSH</b>		
14. MOTHER'S MAIDEN NAME <b>JUSKAUSKAS</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give year or dates of service) <b>554-10-3624</b>		
16. SOCIAL SECURITY NO. <b>554-10-3624</b>			17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBARACHNOID HEMORRHAGE</b> 330 X Conditions, if any, which gave rise to immediate cause (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> (c) <b>HYPERTENSION</b> DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>28 MARCH 1962</b> to <b>29 MARCH 1962</b> that (I) <b>XXX</b> saw the deceased alive on <b>29 MARCH 1962</b> , and that death occurred at <b>115A</b> M, from the causes and on the date stated above.			INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b> <b>5 YEARS</b> <b>10 YEARS</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) <b>XXXXXX</b> attended the deceased from <b>28 MARCH 1962</b> to <b>29 MARCH 1962</b> that (I) <b>XXX</b> saw the deceased alive on <b>29 MARCH 1962</b> , and that death occurred at <b>115A</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Emanuel Milder</b> M.D.			22b. DATE SIGNED <b>29 MARCH 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>EMANUEL MILDER, Capt USAF MC</b>			22d. ADDRESS <b>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 2-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
23d. LOCATION (City, town or county) <b>Arlington</b>		23e. (State) <b>Virginia</b>		23f. ADDRESS <b>1661-94 Hope Rd. S.E. Wash DC</b>	
24. FURNERAL DIRECTOR'S SIGNATURE <b>Sumner Bros</b>			25a. REC'D BY REGISTRAR <b>DATE APR 2 '62</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			25c. REGISTRAR'S SIGNATURE		

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03712

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
5. SEX		6. DATE OF BIRTH	
7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. AGE (In years last birthday)	
9. COLOR OR RACE		10. IF UNDER 1 YEAR	
11. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. IF UNDER 24 HRS.	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14. BIRTHPLACE (State or foreign country)	
15. KIND OF BUSINESS OR INDUSTRY		16. CITIZEN OF WHAT COUNTRY	
17. FATHER'S NAME		18. MOTHER'S MAIDEN NAME	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		20. SOCIAL SECURITY NO.	
21. INFORMANT		Address	
22. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock + Hemorrhage. 982X DUE TO Hemothorax + Cardiac Tamponade DUE TO Stab wound of the chest PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		24. BECKLEY, W. VA. 25. FLORA WASHINGTON, 225 MORRIS AVE., 26. INTERVAL BETWEEN ONSET AND DEATH	
27. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 29. TIME OF INJURY Month, Day, Year Hour XX p.m. 30. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 31. PLACE OF INJURY (Home, farm, city, or other building) 32. (City or town) 33. (County) 34. (State)	
35. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		36. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 37. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 38. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 39. DATE SIGNED 3/27/62	
40. ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		41. ADDRESS (Street, city, town, or county) 3/27/62	
42. BURIAL, CREMATION, REMOVAL (Specify) Burial.		43. DATE THEREOF 3-31-1962	
44. NAME OF CEMETERY OR CREMATORY Greenwood Cem.		45. LOCATION (City, town, or country) (State) Beckley W. Virginia	
46. FUNERAL DIRECTOR W. W. CHAMBERS CO.		47. ADDRESS Riverdale, Md.	
48. REC'D BY REGISTRAR DATE MAR 30 '62		49. REGISTRAR'S SIGNATURE Arthur L. Hume	

00113

00113

James George ... Maryland ...

Seven Heights

D.O.A.

1-01 22nd Avenue

Florida

Florida

Nov. 1, 1900

U. S. A.

West Virginia

Construction

Laborer

Unknown

Unknown

James George ...

Unknown ... Washington, D.C.

James George ...

James George ...

James George ...

X

Strapped during an arrest on

In front of

Seven Heights ...

X

5/26/02

XX

6:45

X

James George ...

James I. ...

James George ...

James George ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03715

03713

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bellmeade, Md</b>		c. LENGTH OF STAY IN 1b <b>37</b> <b>Bellmeade, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>7411 Allison Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Antone</b> Middle <b>A.</b> Last <b>Wenzl</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 62.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b> Hours <b>19</b> Min. <b>62.</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Homes</b>	11. BIRTHPLACE (State or foreign country) <b>Asturiadia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Jacob Wenzl</b>	
14. MOTHER'S MAIDEN NAME <b>Marie Martinek</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>578-36-0382</b>		17. INFORMANT <b>Marie Wenzl Same as #2 (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>154X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1951</b> to <b>3/13 1962</b> that (I) <del>(we)</del> lost saw the deceased alive on <b>3/13 1962</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Dr Frederick Musser</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>3/15/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr Frederick Musser</b>		22d. ADDRESS <b>Bellmeade, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 16, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>MAR 19 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

CERTIFICATE OF DEATH

1977

M

July 2, 1988

Amherst

James Thomas

Robert Gardner

Marie A. James

June 20, 1988

0-2-30-0011 & 0-2-30-0012 (7-12)

1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheltenham</b>				c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>				d. STREET ADDRESS <b>Route # 3, Box 74</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>In a wooded area near Groes Road</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>William</b> <b>West</b>						<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>6</b> Year <b>1962</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec. 22, 1892</b>		<b>9. AGE (in years last birthday)</b> <b>69</b>		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Daniel T. West</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Pinkney</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>				<b>16. SOCIAL SECURITY NO.</b> <b>000-45-6789</b>		<b>17. INFORMANT</b> Address <b>Turner West, Box 129, Route # 2</b> <b>Brandywine, Md.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exposure to cold</b>											
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>932-5</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Exposed to cold during snow storm.</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>March 5, 1962</b> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Cross Road</b>		<b>20f. (City or town)</b> <b>Chltenham, Md.</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>James I. Boyd</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd</b>						<b>DATE SIGNED</b> <b>3/6/62</b>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <b>3-9-62</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON CEM.</b>		<b>22d. LOCATION (City, town, or country)</b> <b>ARLINGTON, VA.</b>			
<b>23. FUNERAL DIRECTOR</b> <b>HUNTER FUNERAL HOME, WASHINGTON, D.C.</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAR 12 '62</b>					
						<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>					

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03718									
CERTIFICATE OF DEATH									
Item 9 Film 0310 4/6/62 jw									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN lb 10 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 64 Hyattsville				
d. STREET ADDRESS 1 4400 Tuokerman Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Albert Middle Paul Last Wheatley					4. DATE OF DEATH Month March Day 31 Year 19 62				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 18 August 1913				
9. AGE (In years last birthday) 48 yrs.					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trial Examiner					10b. KIND OF BUSINESS OR INDUSTRY U. S. Government				
11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME H. Winship Wheatley					14. MOTHER'S MAIDEN NAME Emma Kehoe				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. WW 11				
17. INFORMANT Frances Jackson Wheatley Same as #2 (Wife)					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction secondary to occlusion of the right coronary artery.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Coronary arteriosclerotic heart disease									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
Massive intestinal hemorrhage secondary to idiopathic thrombocytopenia									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 3-21-62 to 3-31-62, 1962, that (I) (we) last saw the deceased alive on 3-31-62 and that death occurred at 6:35 AM from the causes and on the date stated above.									
22a. SIGNATURE Dr. A. Deitz., M.D.									
22b. DATE SIGNED 3-31-62									
22c. PHYSICIAN'S NAME (Type) Dr. A. Deitz., M.D.									
22d. ADDRESS Hyattsville., Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 4/3/62									
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln									
23d. LOCATION (City, town or county) (State) Colmar Manor, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons									
ADDRESS Hyattsville, Maryland									
25a. REC'D BY REGISTRAR DATE APR 3 '62									
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas									

77

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1

B.P.

15M 9/60

Next

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VS. A15ME  
5M 9/60

03716

1147



Prince George's General Hospital

Section 11

*James I. Roy*

Thomas

July 23, 1911

London

10

Washington D.C.

none

none

(3701 Ann St.)

Thomas E. White

(1901) Thomas E. White, 3701 Ann St. (1901)

none

no

London

London

overland, all (white) (white) (white)

*James I. Roy*

U.S.

Section 11

at 1100

10

Association, 1100

1.  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03720

03717

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 701 A St. N. E.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Alice Williams				4. DATE OF DEATH Month Day Year March 26, 19 62			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1905	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid				10b. KIND OF BUSINESS OR INDUSTRY Fraternity House Maryland			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Dyer				14. MOTHER'S MAIDEN NAME Cecelia Matthews			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Sylvia Henson			
17. INFORMANT Same as #2				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X Subarachnoid Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				DATE SIGNED 3/26/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/31/62			
22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park				22d. LOCATION (City, town, or country) Md.			
23. FUNERAL DIRECTOR Johnson & Jenkins 4804 Inwood				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03715

03715



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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the medical examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03721  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
03718

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Camp Springs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6784 Allentown Road</b>				d. STREET ADDRESS <b>1 6784 Allentown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Truman Wilson</b>				4. DATE OF DEATH Month Day Year <b>March 2 1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 17, 1958</b>		9. AGE (In years last birthday) <b>3</b> yrs.	IF UNDER 1 YEAR Months Days <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Earl Truman Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle Virginia Brock</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Myrtle Virginia Wilson, same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO <b>915.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>UNiversal burnes of the body</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Occupant of a house that burned down</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of a house that burned down</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:27 p.m. 3/2 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY OR TOWN <b>Camp Springs P. G. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/2/62</b>			
				Address (Street, city, town, or county) <b>SUITLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-5-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WASH NATIONAL</b>		22d. LOCATION (City, town, or country) (State) <b>SUITLAND MD</b>	
23. FUNERAL DIRECTOR <b>WV CHAMBERS Co</b>				24a. REC'D BY REGISTRAR <b>517-112 ST WASH DC</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2180

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the funeral director. Page 1, 2, and 3 of this certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03722

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03719

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Camp Springs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6784 Allentown Road</b>				d. STREET ADDRESS <b>6784 Allentown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Karen</b> Middle <b>Edith</b> Last <b>Wilson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 30, 1960</b>	
9. AGE (In years last birthday) <b>2</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>62</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Earl Truman Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle Virginia Bock</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Myrtle Virginia Wilson, same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Universal burns of the body</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Occupant of a house that burned down</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of a house that burned down</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:27 p.m. 3/2 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Camp Springs P. G. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/2/62</b>			
				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-5-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WASH NATIONAL</b>		22d. LOCATION (City, town, or country) (State) <b>SUITLAND MD</b>	
23. FUNERAL DIRECTOR <b>WW CHAMBERS CO</b>				24a. REC'D BY REGISTRAR <b>7 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03723

03720

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Raymond</u> Middle <u>Baker</u> Last <u>Windsor</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>6</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31 1882</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Windsor</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217 36 7331</u>		17. INFORMANT Address <u>Blanche O. Windsor, Clinton, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>4-4-2X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>March 5, 1962</u> that (I) (we) last saw the deceased alive on <u>March 5 1962</u> and that death occurred at <u>9:00</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James I. Boyd</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>James I. Boyd</u>				22d. ADDRESS <u>8200 Marlboro Pike S.E.</u> <u>Washington 28, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>March 10 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Piscataway, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u> ADDRESS <u>Waldorf, Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. K... ..</u>	

UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03724		03721	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park - Adelphi c. LENGTH OF STAY IN lb 1 yr. 4 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Saint Branch Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 3804 JUNIPER ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Earl Wolf		DATE OF DEATH Mar. 31 1962	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1893 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Drug Fair	11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.
13. FATHER'S NAME J. Elmer Wolf		14. MOTHER'S MAIDEN NAME Clara Fahrney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		17. INFORMANT Address Nursing Home Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 18 months Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastrointestinal Hemorrhage, Cerebral Vascular Accident			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October 1962 to March 31, 1962, that (I) (we) last saw the deceased alive on March 28, 1962, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Stuart L. Nelson M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-3-60	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City, town or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Jackson		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS 17, Md.		DATE APR 2 '62	

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David Fair

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1893-1894

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03725  
03722

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5621 Hamilton Manor Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Adrian P. Wolff</b>		4. DATE OF DEATH Month Day Year <b>March 20 19 62</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-29-1894</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TYPIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Conn.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>LUCIEN F. WOLFF</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIANNA MURPHY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-01-6357</b>		17. INFORMANT <b>HOSPITAL RECORDS - I-D.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction,</b> DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Heart Disease,</b> DUE TO (c) <b>Cerebral Vascular Accident.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19....., to <b>3/20</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3-20</b> , 19 <b>62</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon R. Gallin M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Leon L. Gallin</b>		22d. ADDRESS <b>7206 Colesville Rd., West Hyattsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/23/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>			
23d. LOCATION (City, town or county)		23e. (State)		23f. (Country)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Nanton - 4748 - N. Ave. Dr.</b>		25a. REC'D BY REGISTRAR <b>MAR 27 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

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Washington, D.C.

1000 1st St. N.E.

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1000 1st St. N.E.  
Washington, D.C.

1000 1st St. N.E., Washington, D.C.

1000 1st St. N.E., Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03726 CERTIFICATE OF DEATH 03723

<b>1. PLACE OF DEATH</b> a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 22 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Gen. Hospital			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville d. STREET ADDRESS 3425 84th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Linda Marie Wright <b>4. DATE OF DEATH</b> Month Day Year March 3 4 19 62			<b>5. SEX</b> Female <b>6. COLOR OR RACE</b> White <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> March 3, 1962 <b>9. AGE</b> (In years last birthday) yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min. 22		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) Md <b>12. CITIZEN OF WHAT COUNTRY?</b>			<b>13. FATHER'S NAME</b> Vernon Dyson Wright <b>14. MOTHER'S MAIDEN NAME</b> Mary Eileen Richardson <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> Address Mother Same as above		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 776X DUE TO Premature birth; B.W. illness Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			<b>21. I certify</b> that (I) (this hospital) attended the deceased from March 3, 1962 to March 4, 1962, that (I) (we) last saw the deceased alive on March 4, 1962, and that death occurred at 6:50 PM from the causes and on the date stated above.		
<b>22a. SIGNATURE</b> M.D. Dr. Jansa <b>22c. PHYSICIAN'S NAME</b> (Type) Dr. Jansa			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> 7403 Varnum Street, Landover Hills Upper Marlboro, Maryland <b>22b. DATE SIGNED</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Cremation <b>23b. DATE THEREOF</b> 3-17-62 <b>23c. NAME OF CEMETERY OR CREMATORY</b> Prince George's Gen. Hosp. Cheverly, Maryland <b>23d. LOCATION</b> (City, town or county) (State)			<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Harry W. Penn, Jr., Administrator <b>25a. REC'D BY REGISTRAR</b> DATE MAR 21 '62 <b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Thomas		

MEDICAL CERTIFICATION

03733

STATE OF DEATH

03733

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03727

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03724

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>2120 Gaither Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2120 Gaither Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Clarence Lee Wyche</b>				4. DATE OF DEATH <b>March 26th., 19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 20, 1918</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Binder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Book Bindery</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Howard Bernard Wyche</b>				14. MOTHER'S MAIDEN NAME <b>Jessie Lee Rakestraw</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give year or dates of service) <b>NW 11</b>				16. SOCIAL SECURITY NO. <b>578-05-4779</b>			
17. INFORMANT <b>Leona Matilda Wyche</b>				Address <b>Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Gun shot wound of head</b> (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot self through head</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self through head</b>			
20c. TIME OF INJURY Month, Day, Year <b>6:45 xx 3/26 19 62</b>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			
20e. (City or town) <b>Hillcrest Hgt's P.G. Md.</b>				(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-28-62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>				22d. LOCATION (City, town, or country) (State) <b>Suitland Md.</b>			
23. FUNERAL DIRECTOR <b>Lee Funeral Home - Washington D.C.</b>				24a. REC'D BY REGISTRAR <b>MAR 28 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



Prince George's

Wilkes-Barre

2750 Galtman Street

Orange

Lee

Wyone

Marion

Edna

Male White

Book Binder

Book Binder

Georgia

U.S.A.

Howard Bernard Wyone

Jessie Lee Holmstrom

Wm H

575-05-779

Leona Keville Wyone

3600 44 42

Heavily and sharp

Gun shot wound of head

x

Shot self through head

6:45 AM 3/26 62

Home

x

Wilkes-Barre P.O. 42

x

x

x

*James I. Boyd*

JAMES I. BOYD, M.D.

3-2-62

Carlisle, Pa.

See serial 1 - Washington D.C.

03721

Prince George's

Wilkes-Barre

Wilkes-Barre

2750 Galtman Street

x

62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03728

## CERTIFICATE OF DEATH

03725

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>77</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston 63</b> d. STREET ADDRESS <b>14909 - 52nd. Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>William H. Zier</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>10</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-3-83</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U S Government</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington D C</b>
<b>13. FATHER'S NAME</b> <b>Jacob B Zier</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ella Pierce</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>220 32 6931</b>		<b>17. INFORMANT</b> <b>Josephine B Zier</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion</b> 54-5 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Bronchopneumonia both side</b> DUE TO (c) <b>Recent partial gastrectomy and gastrojejunostomy</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from 3-5-1962 to 3-10-1962 that (I) (we) last saw the deceased alive on 3-10-1962, and that death occurred at 6:40 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <i>Bernard F. Peacock</i>		<b>22b. ADDRESS</b> <b>4307 Branch Ave. S.E. Unit 21</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Bernard F. Peacock</b>		<b>22d. ADDRESS</b> <b>4307 Branch Ave. S.E. Unit 21</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>3/13/62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ceder Hill Cemetery</b>	<b>23d. LOCATION (City, town or county)</b> (State) <b>Suitland Maryland</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 15 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>			



1. General

2. 1/15/62

3. Cedar Hill

4. Building

5. Building

6. Building, Building